ADULT INFORMATION

PLEASE PRINT CLEARLY **CONFIDENTIAL**

Name_____ Birthdate_____ Gender: M / F

Address _____Social Security # _____-____-_____

City_____ State____ Zip_____ Home phone_____

Cell phone_____Email address:_____

Person to contact in emergency_____ 1st
Phone_____ 2nd Phone_____
Address_____
Relationship to you_____

Employer_____ Work phone_____
Address_____City_____
Occupation:_____ How long employed? _____

Spouse's name_____ DOB _____Social Security # _____-____-_____
Spouse's employer_____ Work phone_____
Address_____
Occupation:_____ How long employed?_____

List persons living in your household and their relationship to you (*including children*):

Name:_____*Age*_____*relation*_____
_____
_____
___
_____
_____

Religious preference_____ Church Attending?_____

Name of referring person/party_____

PROBLEM INFORMATION
Briefly describe your chief concern:_____
_____
_____
_____
_____
_____
_____

Current stressors (*please describe how the following areas are stressful*):

Marriage and home:_____
_____
_____
Children/parents_____
_____
_____
Work/school_____
_____
_____
Financial_____
_____
_____
Social/Emotional_____
_____
_____
Spiritual_____
_____
_____
Sexual_____
_____
Legal/Other_____
_____

Major present stress:_____

Rate how strongly you want to change your present problem on the scale below:
(do not want to change) 1 2 3 4 5 6 7 8 9 10 *(desperately desire change)*

Identify any *specific* concerns or anxieties you have about counseling:_____
_____
_____
What are your *specific* goals for counseling
_____
_____
Previous counseling?_____ When?_____ By whom?_____
How helpful was previous counseling?_____

Eating Disorder Concerns:

Are you currently restricting food? Y/N If so, what is your daily caloric intake?_____
Are you currently binging on food? Y/N Please Describe frequency_____
Are you currently purging after eating? Y/N How many times per day?_____ # of episodes____?
Are you currently wanting to lose weight? Y/N If so, how many lbs?_____
Are you currently exercising/working out? Y/N If so, how many hours a day?_____

Are you currently discouraged by your body image? Y/N Please explain what you would like changed?

_____
_____

PHYSICAL HEALTH
Present health status : *(circle one*): Excellent Good Fair Poor

What serious illnesses have you had and when?_____
_____

Hospitalizations *(reason/diagnosis/dates*)_____
_____
_____

Medications currently taking: (*include non-prescription medications, e.g. sleeping pills, diet pills, etc.*)

MEDICATIONS: DOSAGE: FREQUENCY: PURPOSE:
_____
_____
_____
_____
_____
_____
_____
_____

Prescribed by_____

Current symptoms *(Please circle any that apply to you)*:

Alcohol use, bad home conditions, bowel disturbances, can't make decisions, can't make friends, dizziness, don't like weekends and vacations, drugs, fainting spells, fatigue, feel lonely, depressed, feel unsafe in certain places, financial concerns, Headaches, inferiority feelings, nervousness, nightmares, no appetite, over-ambitious, persistent fears, racing thoughts, recent weight gain, recent weight loss, recurrent troubling thoughts, sexual concerns, shy, sleep disturbances, stomach trouble, suicidal thoughts/feelings, take prescription pills, unable to have a good time, unable to relax others? _____

List any current or past history of alcoholism or drug addiction for you or any family member
_____

List any current or past history of nervous or emotional disorder for you or any family member_____

Completed by:_____ Date:_____