Driftwood Psychological Services
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Client name _____ Date_____

ADULT HISTORY FORM

Presenting problems
Why I came for counseling:

_____

_____

_____

How long have I had the problem? _____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms that are *currently* present)
0 = This symptom is not present at this time
1 = This symptom is present, bothers me a little, but not enough to be a problem.
2 = Symptom present, bothers me and affect my quality of life, but able to function okay
3 = Moderate impact on quality of life and/or day-to-day functioning
4 = Significant impact on quality of life and day-to-day functioning
5 = Serious impact on quality of life and interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Depressed mood	0 1 2 3 4 5	Hearing/seeing things	0 1 2 3 4 5	Thoughts of hurting myself	0 1 2 3 4 5
Worrying	0 1 2 3 4 5	Feel I'm being watched	0 1 2 3 4 5	Thoughts of killing myself	0 1 2 3 4 5
Difficulty concentrating	0 1 2 3 4 5	Feel others are against me	0 1 2 3 4 5	Heart racing	0 1 2 3 4 5
Angry feelings	0 1 2 3 4 5	Loss of interest in things	0 1 2 3 4 5	Twitches/spasms	0 1 2 3 4 5
Angry behavior	0 1 2 3 4 5	Temper outbursts	0 1 2 3 4 5	Knot in stomach	0 1 2 3 4 5
Feeling anxious/nervous	0 1 2 3 4 5	Thoughts coming too fast	0 1 2 3 4 5	Fear of places	0 1 2 3 4 5
Panic attacks	0 1 2 3 4 5	Trouble with memory	0 1 2 3 4 5	Grinding of teeth	0 1 2 3 4 5
Sweaty palms	0 1 2 3 4 5	Chest pain	0 1 2 3 4 5	Back pain	0 1 2 3 4 5
Mind going blank	0 1 2 3 4 5	Cry easily	0 1 2 3 4 5	Upset stomach	0 1 2 3 4 5
Poor appetite	0 1 2 3 4 5	Tiredness/fatigue	0 1 2 3 4 5		
Easily annoyed/irritated	0 1 2 3 4 5	Sleeping too much	0 1 2 3 4 5		
Lump in throat	0 1 2 3 4 5	Sleeping too little	0 1 2 3 4 5		
Difficulty falling asleep	0 1 2 3 4 5	Poor appetite/weight loss	0 1 2 3 4 5		
Difficulty staying asleep	0 1 2 3 4 5	Guilty feelings	0 1 2 3 4 5		

EMOTIONAL/PSYCHIATRIC HISTORY
Have you been in counseling before? ___ Yes ___ No

Name of Counselor	**Counselor Address**	**Counselor Phone No.**	**Dates of service**	**How many sessions?**

Has any family member seen a counselor? ___ Yes ___ No

Which family member?	Relationship to you	What was counseling for?

Were you ever in the hospital for a psychiatric or substance use disorder? ___ Yes ___ No

Name of facility	City and state of facility	Facility phone number	Admission date	For how long?

Has any family member been hospitalized for a psychiatric or substance use disorder? ___ Yes ___ No

Which family member?	Relationship to you	What was the hospital stay for?

Do you take any medication(s)? ___ Yes ___ No If yes, what medication(s) and for which condition(s)? _____

_____

Has any family member used psychiatric medication(s)? ___ Yes ___ No If yes, who/what/why (list all): which condition(s)?

_____

Emotional health problems of family: (check all that apply)

	Mother	Father	Sister	Brother	Aunt	Uncle	Children	Grandparents
Alcohol/drugs								
Anxiety								
Attention Deficit								
Bipolar Disorder								
Depression								
Eating Disorder								
Post-traumatic stress								
Schizophrenia								
Suicide attempt								

FAMILY HISTORY

Describe childhood family experience (circle all that apply):

Outstanding, warm, supportive Normal, adequate, average Inconsistent or chaotic environment

Witnessed physical/emotional/sexual abuse Experienced physical/emotional/sexual abuse

Age of emancipation from home: _____ Circumstances: _____

_____

Special circumstances during childhood: _____

_____

MY MARITAL STATUS	Not currently in a relationship	**People living in my household**			
Single, never married	Never been in a serious relationship	Name	Age	Sex	Rel. to me
Engaged _____ months	Currently in a serious relationship				
Marriage #1 _____ years	Currently living with a partner				
Marriage #2 _____ years	Happy with current relationship				
Marriage #3 _____ years	Current relationship needs work				
Marriage #4 _____ years	Unhappy with current relationship				
Divorce/breakup #1 year: _____ Reason:					
Divorce/breakup #2 year: _____ Reason:					
Divorce/breakup #3 year: _____ Reason:					
Divorce/breakup #4 year: _____ Reason:					

Children who do not live with me (names/ages): _____

_____

Describe any past or current significant issues in intimate relationships:_____

_____

Describe any past or current significant issues in other immediate family relationships:_____

_____

RELIGION/SPIRITUALITY

No	Yes	
		Do you feel that you have a purpose in life?
		Do you believe in a power greater than yourself?
		Do you feel that your morals, beliefs and values have been compromised due to alcohol/drug use?
		Were you raised with a religion as a child?
		If yes, what denomination?
		Do you currently practice any spiritual activities such as praying, attending church, member of choir, reading, mass, meditation, journal?
		If yes, list activities:
		Briefly describe what the word “God” means to you:

Medical history

Describe current health: [ ] Good [ ] Fair [ ] Poor

Name of personal physician: _____

Address: _____ Phone number: _____

Name of psychiatrist (if any) : _____

Address: _____ Phone number: _____

Date of last physical exam: _____

List any abnormal test results: _____

Describe any serious hospitalizations or accidents:

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

Date _____ Age _____ Reason _____

Is there a history of any of the following in the family? (check all that apply)

[ ] Tuberculosis [ ] Birth defects [ ] Emotional problems [ ] Behavioral problems [ ] Thyroid problems [ ] Cancer

[ ] Heart disease [ ] Diabetes [ ] Mental retardation [ ] High blood pressure [ ] Alzheimer's/dementia [ ] Stroke

[ ] Drug abuse [ ] Alcoholism [ ] Other chronic or serious health problems

List any health problems currently being treated or have been treated in the past:

_____ _____ _____

_____ _____ _____

Chronic pain problems

Choose a number from 0-10 that best describes your pain :

0 (no pain) 1 2 3 4 5 6 7 8 9 10 (maximum pain)

Where is the pain located? _____ When did the pain start? _____

How long have you had the pain? _____ How often do you experience pain? _____

Does the pain affect activities (e.g., walking, shopping, exercise, etc.)? _____

What makes the pain worse? _____

What lessens the pain? _____

Addiction history

	Currently using/abusing (list substances used)	Used/abused, quit (check if applies)	Did/health problems due to use
Father			
Mother			
Sister			
Brother			
Aunt			
Uncle			
Cousin			
Grandmother			
Grandfather			
Spouse or partner			
Children			

Self	Age at first use	Used in past 6 months
Alcohol – prefer [ ] Beer [ ] Wine [ ] Liquor		
Amphetamines / Meth / Speed		
Barbiturates / Downers		
Cocaine / Crack		
Hallucinogens (LSD, mushrooms, acid)		
Inhalants (paint, glue, gas)		
Marijuana		
PCP		
Painkillers (morphine / heroin / Oxcycontin)		
Steroids		
Prescription drugs		
Other:		

Check all circumstances that apply to you regarding your use of drugs and/or alcohol:

[ ] Used to sleep [ ] Relieve emotional pain [ ] Relieve anxiety [ ] To avoid withdrawal [ ] To get rid of hallucinations

[ ] Used to relax [ ] Relieve physical pain [ ] Relieve anxiety [ ] To function socially [ ] Morning Use [ ] Used alone

Consequences of substance use:

[ ] Hangovers
[ ] Withdrawal symptoms
[ ] Loss of control of amount used
[ ] Binges
[ ] Seizures
[ ] Medical conditions
[ ] Assaults
[ ] Job loss
[ ] Blackouts
[ ] Tolerance changes
[ ] Suicidal impulses
[ ] Arrests
[ ] Overdose
[ ] Sleep disturbance
[ ] Relationship conflicts
[ ] Legal problems

Treatment history:

[ ] Outpatient [ ] Inpatient [ ] 12-step program [ ] Stopped on own

No Yes

[ ] [ ] Has anybody complained about your substance use? Who? _____
[ ] [ ] Have you ever received a DUI? If yes, how many? _____ Dates _____
[ ] [ ] Have you had any other legal problems where alcohol or drugs were involved? If yes, explain _____
_____

No	Yes	
[ ]	[ ]	Have you ever awakened the morning after using substances the night before and found that you could not remember part of the evening before?
[ ]	[ ]	Have you ever gone for more than three days without using substances without a struggle?
[ ]	[ ]	Did you ever need a drink first thing in the morning to get started?
[ ]	[ ]	Have you had any of the following problems when you stopped or cut down on your substance use? (check all that apply) [ ] Shakes [ ] Seeing or hearing things that aren't there [ ] Heavy sweating, heart beating fast [ ] Unable to sleep [ ] Feeling anxious or depressed [ ] DT's or seizures
[ ]	[ ]	Have you ever used substances to keep from having withdrawal symptoms or to make them go away?
[ ]	[ ]	Did you continue to use substances, knowing it caused you to have health problems or injuries?
[ ]	[ ]	Have you ever continued to use substances while taking medication that was dangerous to take with that substance?
[ ]	[ ]	Have substances ever caused you to feel: [ ] disinterested in things [ ] depressed [ ] paranoid
[ ]	[ ]	Did these problems cause you to cut down on substance use?
[ ]	[ ]	Have you ever spent a lot of time getting, using, or getting over the effects?
[ ]	[ ]	Have there been many days when you used much larger amounts of substances than you intended to when you began?
[ ]	[ ]	Have you tried to cut down on your substance use but found that you couldn't?
[ ]	[ ]	Did you ever feel sick because you stopped or cut down on substance use?
[ ]	[ ]	Have you ever felt you needed larger amounts of substances to get the same effect as before?
[ ]	[ ]	Have substances caused problems with your family, friends, workers, or with the police?
[ ]	[ ]	Have you given up, or greatly reduced, important activities such as sports, work, or associating with friends or relatives in order to use substances?

Self-Evaluation:

Personal Strengths	Personal Weaknesses
_____	_____
_____	_____
_____	_____
_____	_____