Associates in Family Psychology
Adult Client Information Form

Today's Date: _____

Client Name: _____ (First) _____ (Middle) _____ (Last)

Home Address:

_____

_____ (City) _____ (State) _____ (Zip Code)

Client's Birth Date: _____

City/State of Birth: _____

Marital Status (Check One):

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number to Call/Text For Appointment Reminders:

Cell __ Home __ Work __ : _____

Email Address: _____

Reminders are a courtesy and are not guaranteed

Highest Level of Education (Check One):

☐ Less Than High School Diploma
☐ High School Diploma
☐ Some College
☐ Associate's Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctoral Degree

Mailing Address if Different From Above:

_____

_____

Insurance Co Name: _____

Insured's Name: _____

Date of birth: _____

Member ID#: _____

Nearest Relative/Emergency Contact:

_____

Relative/Emergency Contact Phone Number:

_____

Client Occupation: _____

Business Name: _____

Work Address: _____

City/State/Zip: _____

Business Phone: _____

Please let us know how you found out about Associates In Family Psychology (Specify):

☐ Doctor _____
☐ Attorney _____
☐ Friend _____
☐ Yellow Pages
☐ Public/Private Agency _____
☐ Insurance _____
☐ Other _____

Spouse's Name: _____

Spouse's Occupation/Business Name:

_____

Work Address: _____

City/State/Zip: _____

Business Phone: _____

FAMILY INFORMATION: Please list all your children (including adult, step, half and adopted children)

Name	Gender	Age	Birth Date	School	Grade	Live at Home?
	☐M ☐F					☐Y ☐N
	☐M ☐F					☐Y ☐N
	☐M ☐F					☐Y ☐N
	☐M ☐F					☐Y ☐N
	☐M ☐F					☐Y ☐N
	☐M ☐F					☐Y ☐N
	☐M ☐F					☐Y ☐N

Reset Page

Your assistance by providing the following background information about yourself/family in advance is greatly appreciated. This will help your psychologist most efficiently address your concerns. This portion of the form will be part of your confidential clinical file. Your psychologist will review this information with you during the intake; however, if you have specific questions about completing this form, please ask a member of our office staff.

Please briefly describe what brings you here today:

_____

_____

_____

_____

_____

Your Mental Health Treatment History (include inpatient and outpatient): ☐ No Prior Treatment

Provider	Dates of Treatment	Reason for Treatment	Problem/Concern Resolved?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Have you ever attempted suicide or attempted to harm yourself? ☐ Yes ☐ No
If yes, please specify and describe current status:

_____

_____

_____

_____

Your Medical History: ☐ In good health ☐ Medical/Health related concerns

Current physician(s): _____

Current or Prior Health Problems: _____

Hospitalizations? ☐ Yes ☐ No If yes, relevant history:

_____

_____

_____

_____

Currently Taking Medication? ☐ Yes ☐ No If Yes, please complete below.

Medication Name	Dosage	Reason Taken	Taken for how long?

Reset Page

Please provide your psychologist with information regarding your **family** health and emotional history by marking the appropriate column where those problems were present for a particular family member.

Problem Area	Self	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative Specify:
Depression										
Anxiety										
Panic Attacks										
Obsessions/ Compulsions										
Manic depression/ Bipolar disorder										
Psychotic disorder; Hallucinations/delusions										
Alcoholism										
Drug Abuse										
Suicide Attempt										
Learning Problems: Reading, Math, Writing										
AD/HD (Attention Deficit/Hyperactivity Disorder)										
Autism/ Aspergers Syndrome										
Physical, Emotional, or Sexual Abuse										
Eating Disorder										
Thyroid Disorder										
Migraine Headaches										
Serious/chronic health concerns or illness Specify:										
Other:										

Any additional information as needed:

Reset Page

Family of Origin History:

City/State where you were born: _____

Parents: (Please note all parents and indicate if they were step-parents or adoptive parents):

First Name	Age	Living or Deceased?	Live Locally?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Siblings (Please indicate if they were half or step siblings):

First Name	Approximate Age (in order of birth)	Living or Deceased?	Live Locally?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Your relationship with your parents/siblings: ☐ Good ☐ Distant ☐ Poor ☐ Excessive arguing/fighting

Briefly describe as needed:

_____

_____

Marriage Relationship History:

How long have you been married OR in your present relationship? _____ ☐ N/A

If you have been married more than once, please list marriages in order first to last and include dates:

_____

_____

_____

Are you concerned about conflict in your present relationship? ☐ Yes ☐ No ☐ N/A (If Yes, specify):

_____

_____

_____

Social History/Peer Relationships:

How do you best describe your current friendships?

☐ Many good friends ☐ A few close friends ☐ Almost no friends ☐ Several friends, but poor quality

☐ Makes friends, but has difficulty keeping them or have lots of conflict with friends

Briefly describe concerns as needed:

_____

_____

_____

Reset Page

Traumatic Experiences: ☐Yes ☐No (If Yes, specify below):

☐Physical Abuse ☐Verbal/Emotional Abuse ☐Sexual Abuse ☐Neglect

Domestic Violence/Spousal Abuse Sexual Harassment/Assault Death/significant loss/pregnancy loss

Moves/Relocation (Please note place and dates of relocation):

Sleep: ☐No concerns ☐Concerns (check all that apply):

- ☐Trouble falling asleep
- ☐Trouble staying asleep
- ☐Early waking
- ☐Nightmares
- ☐Unusual sleep behavior – Describe: _____

Weight/Eating/Appetite Concerns: ☐No concerns ☐Concerns (check all that apply):

- ☐Eating too much/weight gain
- ☐Not eating enough/weight loss
- ☐Concerned about a possible eating disorder

Academic History:

Typical academic grades: _____

History of learning problems? ☐Yes ☐No

Please note any other relevant information or current learning concerns:

Occupational/Educational Background:

Current job occupation:

Please describe concerns as needed:

Military History? ☐Yes ☐No

If Yes, please specify: _____

Legal History:

Have you ever been charged with a crime? ☐Yes ☐No

Have you ever been the victim of a crime? ☐Yes ☐No

If Yes, relevant history:

Reset Page

Substance Use History (for client):

☐ No substance abuse	☐ Tobacco use	☐ Cocaine
☐ Social drinking	☐ Caffeine	☐ Other
☐ Current alcohol/drug abuse	☐ Steroids	
☐ Prior substance use, but discontinued	☐ Marijuana	
☐ Current/Prior substance treatment	Specify: _____	

Concerns about a family member's substance use? ☐ Yes ☐ No

If Yes, please explain:

_____

_____

Other Concerns: ☐ None

Explain as needed:

_____

_____

_____

Please describe what you would like to accomplish in treatment with your psychologist:

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

4. _____

_____

_____

Thank you for your time, effort and care in providing your doctor with complete information. This will allow you to receive the best possible care, while allowing the doctor to focus more thoroughly on the reason you are coming in today.

Reset Page