Adult History Form

Client's Name: _____ Doctor/Therapist_____

Date: _____ Age_____ Sex: ☐Male ☐Female

Date of Birth: _____ Place of Birth_____

Address_____

City_____ State_____ Zip:_____

Phone Number: (H):_____ (C):_____ (W):_____

Emergency Contact Name/Number: _____

Religion (optional):_____

Name of School: _____ Highest Grade Completed:_____

FAMILY INFORMATION

Marital Status: _____ Name of Spouse:_____

Number of Individuals in your household:_____
Name of Individuals living with you and their relationship to you:

_____
_____
_____
_____

HEALTH

Describe your present physical condition:

_____
_____
_____
_____

Do you drink?:_____ If so, how often and how much?:_____

Do you abuse Narcotics, and/or other substances?:_____

If yes, please explain:_____

Please list all medications you are currently taking. Please provide the name of the physician(s) that prescribe you these medications.

_____
_____
_____

Have you ever seen a counselor/psychiatrist/social worker for this problem or for any problems?:
☐YES ☐NO

If yes, when did you see them and for how long?:
_____
_____
_____
_____

Do you feel you benefitted from this therapy? ☐YES ☐NO

EMPLOYMENT HISTORY:

Do you work?: ☐YES ☐NO

Present Occupation:_____

Place of Employment:_____

How long have you worked at this job?: Years_____ Months_____

Longest job held: Years_____ Months_____

Title and/or name of position:_____

Name three other jobs you've been employed in, and length of employment:
_____
_____
_____

Ever served in the Military? ☐YES ☐NO
If yes, please give dates and positions in Military:
_____
_____

Honorable or Dishonorable Discharge:_____

Signature of Client: _____ Date:_____

Therapist Signature:_____ Date:_____