becker/gibeau

Adult History Form

Doctor/Therapist: _____ Date: _____

Client Name: _____ Age: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ Work: _____

Ethnicity: _____ Religion: _____ Gender: ☐ Male: ☐ Female

Name of School: _____ Highest Grade Completed: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed

Name of Spouse: _____ Number of individuals in your household: _____

Please list individuals living with you:	Age:	Relationship:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health

Describe your physical condition:

Do you Drink? ☐ Yes ☐ No

If YES, how often? _____ If YES, how much? _____

Do you abuse Narcotics, and /or other substances? ☐ Yes ☐ No

If YES, how often? _____ If YES, how much? _____

What medications do you currently take? (Include non-prescription, herbal meds, & supplements)

Medicine	Dose	Frequency	Who prescribes medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Referred By:

☐ Self ☐ Hospital ☐ Physician ☐ CPS

Reason for Referral:

☐ Mental Health ☐ Family/Friend ☐ School ☐ Court ☐ Substance Abuse ☐ Zero Tolerance

☐ Other: _____

Have you seen a counselor/psychiatrist/social worker? ☐ Yes ☐ No

If yes, when and where? _____

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

Do you feel benefitted from this therapy? ☐ Yes ☐ No

Employment History

Do you work? ☐ Yes ☐ No

Present Occupation: _____

Place of Employment: _____Time at job:_____

Longest job held: Years:_____ Months:_____

Title and/or name of position: _____

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

Position: Date:

_____ _____

_____ _____

_____ _____

Have you ever served in the Military? ☐ Yes ☐ No

Position: Date:

_____ _____

_____ _____

_____ _____

Honorable or Dishonorable Discharge: _____

_____ _____

Signature of Client Date

_____ _____

Therapist Signature Date