ADULT INFORMATION

Date: _____

Patient's Information:

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Phone: _____ Social Security (for insurance purposes): _____

Marital Status: ____ Married ____ Single ____ Divorced ____Separated ____Widowed

Spouse Name: _____Phone: _____

Emergency Contact Person: _____

Relationship: _____ Phone:_____

Employment: _____ Phone: _____

Education: Highest Grade Completed: _____ Highest Degree Earned: _____

Referred by: _____

Legal issues Pending ____ yes ____ no If yes, explain: _____

What are you most concerned about today? _____

_____

Tell my about any dangerous behavior: _____

Have you had treatment for this problem before? _____ If yes, where? _____

What do you want out of life? _____

Physical condition: poor fair average good
Emotional condition: poor fair average good
Spiritual condition: poor fair average good

Circle the words that describe why you need counseling:

Addiction	Fear	Loss of meaning	Relationship with Children
Adultery	Grief	Loss of faith in others	Self-doubt
Anger	Guilt	Loneliness	Self-injury
Anxiety	Impotency	Marriage Problems	Sexual Concerns
Cutting	Loss of hope	Nerves/Nervousness	Other: _____
Depression	Loss of faith	Relationship Problems	

Patient Signature: _____ Date: _____

MENTAL STATUS EXAM

Appearance: ____ Well Groomed ____ Dirty/Dishevel ____Obese ____Average ____Slim

Behavior: ____ Appropriate ____ Dependent ____ Resistant ____ Cooperate ____ Sarcastic ____ Guarded

Motor Activity: ____ Non-remarkable ____Tremulous _____Restless ____Slurred Speech ____Agitated

Mood/Affect: ____ Normal ____ Anxious ____ Sad/Depressed ____ Angry ____ Labile ____ Flat/Blunted ____ Guarded ____ Irritable ____ Other

Thought Content: ____ Realistic/Oriented ____ Disorganized ____ Flight of ideas ____ Delusional ____ Paranoid ____ Obsessions ____ Hallucinations (Auditory, Visual, Tactile, Olfactory)

Current Suicidal Thoughts? ____ yes ____ no If yes, how would you do it?_____

_____

History of Suicidal Behavior? ____ yes ____ no Specify (thoughts, plans, gestures or attempts):

_____

Current Homicidal Thoughts? ____ yes ____ no If yes, explain. _____

History of Homicidal Behavior? ____ yes ____ no (Assaultive thoughts, plans, gestures or attempts):

_____

Violent Behavior (recent or remote) _____

Have you ever been a victim of abuse, sexual or physical? ____ yes ____ no

_____

Family history of psychiatric/chemical dependency problems? ____ yes ____ no

_____

Has any family member ever attempted suicide? ____ yes ____ no (who, when, how)

_____

CHEMICAL DEPENDENCY

Use of.... Yes/No	How Much	Last Use
Alcohol		
Tobacco		
Sedatives/Tranquilizers: Xanax, Valium, etc		
Stimulants: Speed, diet pills		
Sleeping Pills		
Opioids: Demerol, Lortab, Percodan, Codeine		
Marijuana		
Hallucinogens: LSD, PCP		
Heroin/Methadone		
Cocaine/Crack/Base		
Inhalants: glue, gas, paint		
XTC		

Withdrawal Symptoms: _____

Significant Periods of Sobriety: _____

Current Medical Problems: _____

Current Medications: _____

Primary Care Physical: _____

Recommendations: _____

Application Form Completed by: _____