Therapeutic Life COUNSELING, PC

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Adult Demographic Form

Instructions: Please fill out this form as completely as possible. provide the most accurate information to date.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Religion: _____

Home Address:

_____
Street City State ZIP

Social Security #: _____ Occupation: _____

Where Employed: _____ For How Long: _____

Highest Educational Level Obtained: _____

Contact Phone Numbers:

Email: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

Home Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

Referral Information:

How were you referred to Therapeutic Life Counseling, PC?

_____

May we have your permission to thank them? Yes No

If via the Internet, please indicate the website: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____

Medical/Physical Information:

Present physical health problems: _____
_____

Current medications: _____
_____

Past medical history: _____
_____
_____

Your current physician:

Name of primary care physician: _____
Phone #: _____
Fax #: _____

Other specialists that you currently see:

Name of specialist: _____
Phone #: _____
Fax #: _____

Name of specialist: _____
Phone #: _____
Fax#: _____

How often & how much alcohol do you consume? _____

Do you use recreational drugs and if so, how often?_____

Relationship Information:

Relationship Status:

Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Cohab. ___

Partner's name (if applicable): _____ Age: _____ Gender: _____

Occupation: _____ Where employed: _____

Education: _____ Religion: _____

Length of relationship/marriage: _____

Quality of relationship/marriage at this time: _____

Date(s) of your former marriage(s) (if applicable): _____

Names and ages of children (of yours and/or your partners): _____

_____

With whom do you currently live? _____

Family History:

Mother's age: ____ Occupation: _____ Health: _____

Describe your relationship: _____

If deceased, your age at the time of her death: _____

Father's age: ____ Occupation: _____ Health: _____

Describe your relationship: _____

If deceased, your age at the time of his death: _____

If divorced/separated, your age at that time: _____

If remarried, names of stepparents and length of relationships: _____

_____

Name and age of siblings: _____

If you were not raised by your parents, who raised you? _____

Any history of neglect, and/or physical, verbal, emotional, spiritual, or sexual abuse? _____

_____

Any family history of substance abuse, mental illness, suicide, or violence? _____

_____

Previous Therapy or Psychological Testing Experience:

Have you had any previous counseling, therapy, or psychological/neuropsychological testing?

Yes No Describe: _____

If yes, please indicate specifics below:

Clinician/Practice's Name: _____

Clinician's Specialty (i.e. psychology, social work, psychiatry, other): _____

Dates Seen: _____

Type of Testing/Treatment: _____

Outcome/Results: _____

Clinician/Practice's Name: _____

Clinician's Specialty (i.e. psychology, social work, psychiatry, other): _____

Dates Seen: _____

Type of Testing/Treatment: _____

Outcome/Results: _____

Social History:

Describe your relationship with friends: _____

How would you describe your social support network? _____

Describe your hobbies/interests: _____

_____

Describe any cultural concerns: _____

How important are religious/spiritual issues to you? Not Important Average Very Important

Present Concerns:
(Please mark any you are experiencing)

Mood Problems:

___ Depressed Mood
___ Changes in Sleep
___ Changes in Appetite
___ Crying Spells
___ Fatigue
___ Problems Concentrating
___ Suicidal Thoughts/Attempts
___ Elevated Mood
___ Feeling Restless/Irritable
___ Impulsive Behavior
___ Decreased Sleep
___ Agitation
___ Rapid Speech
___ Racing Thoughts

Anxiety Problems:

___ Feeling Nervous/Worried
___ Unrealistic Fears
___ Feelings of Panic
___ Social Anxiety
___ Obsessions/Compulsions
___ Nightmares
___ Flashbacks

Substance Use/Eating Disordered Problems:

___ Excessive Alcohol Use
___ Recreational Drug Use
___ Recurrent Binge Eating and/or Purging
___ Restricted Eating Pattern
___ Excessive Exercising

Problems with Behavior/Thoughts:

___ Difficulty Paying Attention
___ Losing Things
___ Difficulty Organizing
___ Easily Distracted
___ Forgetful
___ Fidgeting
___ Difficulty Remaining Seated
___ Talking Excessively
___ Difficulty Waiting
___ Experiencing Hallucinations
___ Aggressive toward People
___ Destructive toward Property
___ Sexually Aggressive
___ Cutting or Harming Self
___ Stealing
___ Often Lose Temper
___ Relationship Problems
___ Homicidal Ideation

Physical Problems:

___ Headaches
___ Muscle Tension
___ Stomachaches
___ Other – Please Indicate: _____
___ Neck/Back Pain

Please give a description of your current concerns:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please summarize your goals for counseling/therapy:

_____

_____

_____

_____

_____

_____

Is there any additional information that you believe to be important for us to know in order to provide you with the best care possible?

_____

_____

_____

_____

_____

_____

Thank you for taking the time to fill out this form!