Fresh Start for the Mind, LLC
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ADULT HISTORY FORM

Client name: ____ **Date:**____________________

Client Address:____

Client DOB (Age): ____

Client Phone: _________________________________ **Email Address:**_________________________

Gender: ☐Male ☐Female ☐Transgender ☐Other:______________________________

Ethnicity (please specify): ____________________________________ **First Language**:________________

What are your personal concerns?____

____

How long have you had these concerns or this problem? __________________________________

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms that are *currently* present)
0 = This symptom is not present at this time
1 = Mild impact on quality of life and/or day-to-day functioning
2 = Moderate impact on quality of life and/or day-to-day functioning
3 = Serious impact on quality of life and interferes with day-to-day functioning

Symptom	Severity	Symptom	Severity	Symptom	Severity
Depressed mood	0 1 2 3	Easily annoyed/irritated	0 1 2 3	Tiredness/fatigue	0 1 2 3
Worrying	0 1 2 3	Hearing/seeing things	0 1 2 3	Cry easily	0 1 2 3
Difficulty concentrating	0 1 2 3	Feel I'm being watched	0 1 2 3	Headaches/Migraines	0 1 2 3
Feeling anxious/nervous	0 1 2 3	Feel others are against me	0 1 2 3	Pain	0 1 2 3
Racing thoughts	0 1 2 3	Loss of interest in things	0 1 2 3	Feelings of guilt or shame	0 1 2 3
Panic attacks	0 1 2 3	Loneliness	0 1 2 3	Low self-esteem	0 1 2 3
Over-eating/weight gain	0 1 2 3	Stomach problems	0 1 2 3	Thoughts of hurting myself	0 1 2 3
Poor appetite/weight loss	0 1 2 3	Trouble with memory	0 1 2 3	Thoughts of killing myself	0 1 2 3
Body image concerns	0 1 2 3	Chest pain/heart racing	0 1 2 3	Thoughts of hurting others	0 1 2 3
Anger/temper outbursts	0 1 2 3	Difficulty with sleep	0 1 2 3	Thoughts of killing others	0 1 2 3

MENTAL HEALTH HISTORY

Have you been in counseling before? ☐ Yes ☐ No (If yes, fill in information below. Use back of sheet if needed.)

Approx. Dates: _____________ # of Sessions: ____ Counselor's Name: _________________________ Location: __________

Approx. Dates: _____________ # of Sessions: ____ Counselor's Name: _________________________ Location: __________

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Have you ever been in the hospital for a psychiatric or substance abuse disorder? ☐ Yes ☐ No
(use back of sheet if needed)**:**

Approx. Dates: _____________ How long: _______ Facility Name: __________________________ Location: ____________

Approx. Dates: _____________ How long: _______ Facility Name: __________________________ Location: ____________

Approx. Dates: _____________ How long: _______ Facility Name: __________________________ Location: ____________

Have you ever been diagnosed with a psychiatric disorder? ☐ Yes ☐ No

If yes, what diagnosis(es)?____

____

Do you currently take, or have you previously taken, any psychiatric medication(s)? ☐ Yes ☐ No

If yes, what medication(s) and for which condition(s)?____

____

Prescriber's Name: ______________________ Phone: ______________ Location: __________

FAMILY MENTAL HEALTH HISTORY

Please see the list of emotional health problems below and check all that apply

	Mother	Father	Sister	Brother	Aunt	Uncle	Children	Grandparents
Alcohol/drugs								
Anxiety								
Attention Deficit								
Bipolar Disorder								
Depression								
Eating Disorder								
Post-traumatic stress								
Obsessive-Compulsive								
Schizophrenia								
Suicide attempt								
Learning Disability								
Autism Spectrum								
Other:								

FAMILY AND RELATIONAL HISTORY

Where were you born and raised? ____

Check all that apply regarding your childhood family experiences:

☐ Outstanding ☐ Warm ☐ Supportive ☐ Normal ☐ Adequate ☐ Average ☐ Inconsistent ☐ Chaotic ☐ Jealousy
☐ Intense sibling rivalry ☐ Witnessed physical/emotional/sexual abuse ☐ Experienced physical/emotional/sexual abuse

Special circumstances during childhood: ____

____

____

Sexual Orientation: ☐Heterosexual ☐Gay ☐Lesbian ☐Bisexual ☐Questioning ☐Asexual ☐Other:_________

Relationship status (check all that apply)**:** ☐ Single ☐ Married ☐ Engaged ☐ Divorced ☐ Separated

☐ Involved in a serious relationship ☐ Living w/ Partner ☐ Never been in a serious relationship

☐ Happy w/current relationship ☐ Current relationship needs work ☐ Unhappy w/current relationship ☐ On verge of break up

If Married or Partnered: # of Marriages ________ # of Months/Years of each: #1_________ #2_________ #3_________

If divorced: Date of divorce:_________________ Reason:____

Date of divorce:_________________ Reason:____

Date of divorce:_________________ Reason:____

People living in your household (use back of sheet if needed)**:**

Name: ______________________________ Age:_______ Gender: _______ Relation to you: ________________

Name: ______________________________ Age:_______ Gender: _______ Relation to you: ________________

Name: ______________________________ Age:_______ Gender: _______ Relation to you: ________________

Name: ______________________________ Age:_______ Gender: _______ Relation to you: ________________

Children who do not live w/ you (names and ages)**:** ____

Describe any past or current significant issues in intimate relationships or immediate family: ____________________

____

RELIGION/SPIRITUALITY

Briefly describe you religious or spiritual beliefs (if any): ____

____

Do you feel that you have a purpose in life? ☐ Yes ☐ No **Do you believe in a power greater than yourself?** ☐ Yes ☐ No

Were you raised with religion or spirituality as a child? ☐ Yes ☐ No If yes, please specify: __________________

Do you currently practice any spiritual activities such as praying, church, reading, meditation, etc.? ☐ Yes ☐ No

OCCUPATIONAL HISTORY

Are you currently employed? ☐ Yes ☐ No If yes, where:____

Are you satisfied with your current job? ☐ Yes ☐ No If no, explain:____________________________________

____

If not currently employed, have you ever been employed? ☐ Yes ☐ No If yes, where:______________________

____

ACADEMIC HISTORY

Are you currently attending school (college, vocational, etc.)? ☐ Yes ☐ No If yes, where:____________________

Highest education obtained: ☐HS diploma ☐GED ☐Some college ☐Associates ☐Bachelors ☐Graduate Degree

High School GPA:___________ **College GPA:**______________ **Major:** ______________________________

Special classes/Accommodations:________________ **Repeated grades:**________ **Behavioral issues:** ☐ Yes ☐ No

MEDICAL HISTORY

Describe your current health: ☐ Good ☐ Fair ☐ Poor

Name of primary care physician: ______________________ **Phone:** __________________ **Location:** ________

Date of last physical exam: _______ **List any abnormal test results:** ___________________________________

List any serious hospitalizations or accidents (use back of sheet if needed)**:**

Date: ________________________ Age: _____ Reason: ____

Date: ________________________ Age: _____ Reason: ____

Is there a history of any of the following in the family? (check all that apply)

☐ Tuberculosis ☐ Birth defects ☐ Emotional problems ☐ Behavioral problems ☐ Thyroid problems ☐ Cancer ☐ Heart disease
☐ Diabetes ☐ Mental retardation ☐ High blood pressure ☐ Alzheimer's/dementia ☐ Stroke ☐ Other serious health problems

List any health problems for which you are currently being treated or have been treated in the past:

________________________________ ________________________________ ________________________________

________________________________ ________________________________ ________________________________

Do you take any medication(s) for medical conditions? ☐ **Yes** ☐ **No** If yes, what medication(s) and for which conditions?

____

____

Chronic pain problems: Choose a number from 0-10 that best describes your pain

(no pain) 0 1 2 3 4 5 6 7 8 9 10 *(maximum pain)*

Where is the pain located? ________________________________ **How often do you experience pain?** ________________

SUBSTANCE USE HISTORY

	Age at first use	Used in past 6 months (if so, when)	How often
Alcohol – preference ☐Beer ☐Wine ☐Liquor			
Amphetamines / Meth / Speed			
Barbiturates / Downers			
Cocaine / Crack			
Hallucinogens (LSD, mushrooms, acid)			
Inhalants (paint, glue, gas)			
Marijuana			
PCP			
Painkillers (morphine / heroin / Oxycontin)			
Steroids			
Prescription drugs			
"Molly"/Ecstasy			
Other:			

Consequences of, or negative experiences during, substance use (please check all that apply)**:**

☐ Hangovers ☐ Withdrawal symptoms ☐ Loss of control of amount used ☐ Binges ☐ Seizures ☐ Medical conditions
☐ Assaults ☐ Blackouts ☐Tolerance changes ☐Suicidal impulses ☐Arrests (including DUI) ☐ Legal problems
☐Overdose ☐Sleep disturbance ☐Relationship conflicts ☐ Job loss

Have you ever received treatment for Alcohol and/or substance abuse? ☐ Yes ☐ No

☐ Outpatient ☐Inpatient ☐12-Step program ☐Stopped on own **Please Explain:**__________________________

____

SELF-EVALUATION

Personal Strengths: ____

Personal Weaknesses: ____

Hobbies/Interests: ____

Thank you,

Fresh Start Staff

For office use only:

DOI:	**Attendee(s):**
DOE:	