Adult Background Information

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Details will be discussed in your intake session.

Name: _____ *First Visit Date:* _____
Last First MI

*Pronouns:*_____

Home Phone: _____ (***May call***: Yes No ***Message***: Yes No)

Cell Phone: _____(***May call***: Yes No ***Message***: Yes No)

Work Phone: _____ (***May call***: Yes No ***Message***: Yes No)

Home Address:

_____
Street City State Zip

Best time/place to contact you: _____ Occupation: _____
In case of emergency, contact:

_____
Name: Last, First Relationship Phone

Gender: Male___ Female___ Other_____
*Date of Birth*_____ *Age*___

Ethnicity:
Africa American___ Bi-racial___ Hispanic/Latin___
Asian___ Caucasian___ Native American___ Other _____

Are you currently in counseling elsewhere? Yes No *(If yes, do not complete this form until you have spoken with me)*

Are you seeking services because you are a victim of a crime? Yes No
Did it result in legal action? Yes No

Are you currently on probation? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)?
Yes No
Previous Mental Health Professional/Agency_____
Name Address
Phone_____ Dates of Service_____ (beginning - ending)

Have you ever been hospitalized for mental health concerns: Yes No
If yes please explain:
_____

How were you referred to Dr. Stulmaker? (Check those that apply):
Counselor/Psychologist/Psychiatrist__ School personnel__
Court__ Minister___ Self__
Flyer__ Physician__ Online Search__
Friend or Co-Worker__ Relative___ Other_____

Educational Level:
8th grade or below _____ Trade School ___ Master's Degree ___
High School ___ Some College ___ Ph. D. Degree ____
GED ___ College Graduate ___

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____
Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

If divorced, circle the number which best describes your relationship with your ex-spouse.
Hostile Frustrating Friendly
1_____2_____3_____4_____5

Are your currently involved in a custody dispute: Yes No (If yes, explain)
_____

_____

Current living arrangements: Family of origin___ Relatives___ Single ___
Married___ Roomates(s)___ Single parent w/children___
Married w/children___ Significant other___ Other_____

Present Family
If married with children, list your family, beginning with the oldest member and include yourself.
Name Age Gender Relationship to you (include step, half, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family of Origin Primary Household (Family in which you resided the majority of your life)
List your family members, by household, beginning with the oldest member (include parents and self):
Name Age Gender Relationship to you (include step, half, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Family of Origin Second Household (if applicable)

Name Age Gender Relationship to you (include step, half, etc.)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Mother's Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married___
Married_____ Remarried_____ Divorced_____
Separated_____ Widowed_____ Unknown_____
Number of Marriages_____

Father's Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married___
Married_____ Remarried_____ Divorced_____
Separated_____ Widowed_____ Unknown_____
Number of Marriages_____

HEALTH

*Primary Care Physician:*_____
Name Address Phone

Psychiatrist:_____
Name Address Phone

Date of LAST complete physical: _____
Physical Disability: Yes No (if yes, explain)
_____
Chronic Illness: Yes No (if yes, explain)
_____
Terminal Illness: Yes No (if yes, explain)
_____

Check the following items for a diagnosis or medication you are now receiving or have received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

If you have been diagnosed, who gave the diagnosis?
Counselor/Psychologist___ Family Physician___ Psychiatrist___ School___ Other_____
Name: _____ Phone #: _____
List other medication you are currently taking
Med._____ Dosage_____
Med._____ Dosage _____
Med._____ Dosage_____

CURRENT CONCERNS

Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) <u>Circle the item that you see as the most significant issue</u>)

___Abuse (physical, emotional, sexual)
___Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
___Career Dissatisfaction or decisions
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Family or Step-family relationship
___Feeling angry or irritable
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling guilty or shameful
___Feeling sadness or depression or suicidal urges <u>NOT related to grief</u>
___Feeling sadness or depression or suicidal urges <u>related to grief</u>
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (repeated run-ins with the law, etc.)
___Learning/Academic difficulties
___Non-family relationship (roommates, friends, co-worker, boss, teacher, etc.)
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Personal Growth (no specific problem)
___Religious or Spiritual concerns
___Sexual functioning concerns
___Sexual identity concern
___Significant other/spouse relationship
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Other (explain_____)

Remember to circle the most significant issue.
When did you first become concerned about this issue? _____
How have you attempted before now to deal with this issue? _____
_____
Other treatment you have received to address any of the concerns indicated above: None___
Couples Counseling___ Group counseling___ Individual counseling___
Family counseling___ Hospitalization___ Other _____
Anything else you think I need to know:

_____

What is the one thing I need to know to help you today?

_____

FAMILY HISTORY/EXPERIENCES

(For each of the following items that apply, write in your approximate age at the time it occurred):
Raised by:
Adoptive parent(s)___ Institution___ Relatives___
Foster parents___ Natural parents___ Single natural parent___
Grandparents___ Natural and step-parent___ Other_____

Stressors in the Family:
Chronic illness of family member___ Death of significant person___ Domestic Violence____
Family member absent (explain)_____
Family member's disability/major accident/illness_____
Family member emotional problems (explain)_____
Family member suicide (explain)_____
Financial problems___ Moved a lot___ Parents arguing frequently___ Parents divorced___
Other _____
History of learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____
History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____
History of family violence: Yes No
(If yes, please explain) _____
History of criminal activity: Yes No
(If yes, please explain) _____

Abused (check all that apply): Physically___ Emotionally___ Sexually___
Neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply):
Academic problems___ Discipline problems___ Severely teased___ Unpopular___
Other _____
Early Language/Speech Problems (explain)_____

Emotional Concerns:
Appetite change ___ Heard voices___ Suicidal thoughts___
Emotional problems___ Loss of energy or fatigue___ Suicide attempts___
Gained weight ___ Lost weight___ Other _____

Behavior Problems (check all that apply):
Accident-prone___ Aggressive Behavior (explain)_____
Alcohol/drug use___ Attention problems___ Frequent arguments___ Hyperactive___
Impulsive___ Loner___ Misbehaved a lot___ Ran away___
Taken advantage of___ Temper outbursts___ Trouble with the law___ Other_____

Anxiety Symptoms (indicate all that apply):
Irritable ___ Obsessive worrying ___ Physical symptoms (below) ___
Keyed up, on edge ___ Phobias ___ Other _____

Health/Physical Problems (check all that apply):
Asthma___ Disability___ Nervous stomach ___
Bedwetting___ Dizziness ___ Neurological problems/exam___

Bone/joint/muscle ___ Headache (kind) ___ PMS ___
Chest pain ___ Heart Palpitations___ Serious overeating/undereating__
Chronic illness___ Hospitalization___ Shortness of breath without exertion ___
Developmental delay(s)___ Major accident___ Sleep problem___
Diarrhea ___ Major illness___ Surgeries___ Other_____

Dissociative Symptoms (check all that apply):
Amnesia of large parts of childhood after age 5___ Things of yours that are missing___
Memories suddenly flashback___ Trance-like episodes/lost track of time___
Things appear but you don't know origin___ Walk in sleep___

Trauma/Stressor (check all that apply):
Child separated from parent (how long and when)_____
Death of a pet___ Death of a significant person___ Incarcerated family member___
Medical___ Natural Disaster___ Sexual Assault___
Victim of trauma (unusual, terrifying experience)___ Other_____

Interpersonal Problems (check all that apply):
Aggressive behavior (explain)_____
Bullied___ Taken advantage of___
Frequent arguments___ Temper outbursts__
Loner___ Other_____

Specific to Adulthood (check all that apply):
Abortion___
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment, etc.)___
Parent/Discipline problems____ Placing child for adoption____ Sexual problem____

Any other significant information: