Texas Premier Counseling Services

www.TexasPCS.org
(972) 895-2502
Support@TexasPCS.org

ADULT INFORMATION FORM

Full Name: _____
First *Middle* *Last*

Date of Birth: _____ Age: _____ Gender: ○ MALE ○ FEMALE

Medical History

Name of Primary Care Physician:_____

Physician Address: _____ Physician Phone: _____

Date of Last Medical Evaluation: _____ Date of Next Appointment: _____

Are you currently under the care of a psychiatrist or been treated by a psychiatrist in the past? ○ YES ○ NO

If YES, Psychiatrist Name_____

Psychiatrist Address: _____ Psychiatrist Phone: _____

Date of last Psychiatric Appointment: _____ Date of Next Appointment: _____

Often times it is best to coordinate treatment with a Primary Care Physician or a Treating Psychiatrist for a continuity of care. Do you consent to coordinate care with the above Physicians?

Primary Care Physician _____ ○ YES ○ NO ○ N/A

Treating Psychiatrist _____ ○ YES ○ NO ○ N/A

Please sign here for either answer: _____

Current medications being taken:

1 . _____ Dosage/Freq:_____ Start Date: _____ Purpose: _____

2 . _____ Dosage/Freq:_____ Start Date: _____ Purpose: _____

3 . _____ Dosage/Freq:_____ Start Date: _____ Purpose: _____

4 . _____ Dosage/Freq:_____ Start Date: _____ Purpose: _____

Prescribed by:_____

Medical History Continued

Have you ever been hospitalized for medical or psychiatric reasons? ○ YES ○ NO

Hospital	Month / Year	Reason

Have you ever been in counseling/therapy for any reason? ○ YES ○ NO

Counselor / Therapist	Month / Year	Reason

Do you use any recreational drugs? ○ YES ○ NO If NO, have you used previously? ○ YES ○ NO

If YES, please list:

Type of Drug	Quantity	How Often	Date Stopped

Do you drink alcohol? ○ YES ○ NO If NO, did you drink alcohol? ○ YES ○ NO

If YES, please list:

Type of Alcohol	Quantity	How Often

Describe any important medical history, chronic ailments, or other health problems you experience:

_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

_____

_____

_____

Do you have any close relatives (*father, mother, brother, sister, grandparent*) who have experienced depression, anxiety, or other emotional difficulties? ○ YES ○ NO If YES, please list:

_____

_____

_____

School and Family History

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? ○ YES ○ NO If YES, please explain below:

_____

_____

_____

Highest level of education: ☐ High School ☐ Some College ☐ Undergraduate ☐ Post-Graduate

If you did not complete high school, please explain: _____

Please list schools (1) Currently Attending, (2) Last Attended, (3) Graduated:

1) School(s)_____ Year(s)_____

(2) School(s)_____ Year(s)_____

(3) School(s)_____ Year(s)_____

How would you describe your current support network? (*friends, relatives, etc.*): _____

_____

Please check **all** of the information that applies to your biological parents:

Mother	☐ Living	**Father**	☐ Living
	☐ Deceased		☐ Deceased
	☐ Divorced		☐ Divorced
	☐ Remarried _____# of times		☐ Remarried _____# of times

Do you consider someone other than your biological parents (step-parent, grandparents, etc.) to be one or both of your "real" parents? ○ YES ○ NO If YES, whom and what is their legal relationship to you?

_____

Where do your parents live?

Mother: _____

Father: _____

*Describe your relationship with your **mother** while growing up:* _____

_____

Currently: _____

*Describe your relationship with your **father** while growing up:* _____

_____

Currently: _____

Did you experience any of the following in your family while growing up? (*Check **all** that apply.*)

☐ Alcohol Abuse ☐ Drug Abuse ☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse

Did you witness any of the following in your family while growing up? (*Check **all** that apply.*)

☐ Alcohol Abuse ☐ Drug Abuse ☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse

Please explain, if any above is checked:

_____

_____

_____

_____

_____

Marital History

Marital Status:

☐ Single / Never Married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Living with Someone

If currently **married**, how long: _____. If **living with** someone, how long: _____.

If **separated/divorced**, how long: _____. If **widowed**, how long: _____.

Please list your children:

Name	Age	Relationship (*natural, step, half, etc.*)	Lives With

Texas Premier Counseling Services

www.TexasPCS.org
(972) 895-2502
Support@TexasPCS.org

About You

Please check all of the items below that currently apply. Feel free to add any other concerns under "Other":

- ☐ Abuse: Specify _____
- ☐ Failure
- ☐ Aggression
- ☐ Fears
- ☐ Financial Troubles
- ☐ Friendship Problems
- ☐ Gambling
- ☐ Grieving
- ☐ Guilt Headaches, Pains
- ☐ Re-Marriage
- ☐ Sadness
- ☐ Self-Abuse
- ☐ Self-Control
- ☐ Self-Esteem
- ☐ Separation
- ☐ Sexual Conflicts
- ☐ Shyness
- ☐ Sleep-Nightmares
- ☐ Step-Parenting
- ☐ Stress
- ☐ Suicidal Thoughts
- ☐ Violence
- ☐ Weight & Diet Issues
- ☐ Withdrawal, Isolating
- ☐ Medical Concerns
- ☐ Other: _____
- ☐ Other: _____
- ☐ Emptiness
- ☐ Obsessions
- ☐ Fatigue
- ☐ Oversensitive
- ☐ Panic or Anxiety Attacks
- ☐ Parenting
- ☐ Perfectionism
- ☐ Phobias
- ☐ Relationship Problems
- ☐ Children-Custody
- ☐ Choices I Have Made
- ☐ Codependence
- ☐ Compulsions
- ☐ Concentration Problems
- ☐ Confusion
- ☐ Crying
- ☐ Deaths
- ☐ Debt
- ☐ Decision Making
- ☐ Dependence
- ☐ Depression
- ☐ Divorce
- ☐ Eating-Making Myself Vomit
- ☐ Eating - Over Eating
- ☐ Eating - Under Eating
- ☐ Eating Other: _____
- ☐ Other: _____
- ☐ Mood Swings
- ☐ Outbursts
- ☐ Anger
- ☐ Anxiety
- ☐ Arguing
- ☐ Attention Problems
- ☐ Career Concerns
- ☐ Childhood Issues (*your own childhood*)
- ☐ Health
- ☐ Hostility
- ☐ Impulsiveness
- ☐ Indecision
- ☐ Inferiority Feelings
- ☐ Inhibitions
- ☐ Interpersonal Conflicts
- ☐ Irresponsibility
- ☐ Irritability
- ☐ Judgment Problems
- ☐ Laziness
- ☐ Legal Matters
- ☐ Loneliness
- ☐ Loss of Control
- ☐ Low Frustration Tolerance
- ☐ Marital Conflict
- ☐ Marital Infidelity / Affairs
- ☐ Other: _____
- ☐ Other: _____

What activities or hobbies do you participate in? _____

_____

Do you participate in regular exercise? ○ YES ○ NO Describe: _____

Describe your current working environment: _____

_____

Have you had any change in sleeping habits? ○ YES ○ NO Describe: _____

_____

Have you had any change in eating habits? ○ YES ○ NO Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? ○ YES ○ NO

If YES, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? ○ YES ○ NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? ○ YES ○ NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? ○ YES ○ NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? ○ YES ○ NO

If yes, please explain: _____

Thoughts

Please check any of the following that apply to you:

☐ I sometimes hear voices even though no one nearby is talking to me.

☐ I sometimes feel that forces outside of me control me.

☐ I sometimes feel that other people control my thoughts.

☐ I sometimes have the same thought over and over and cannot control it.

☐ I sometimes feel that someone is out to hurt me or do something against me.

☐ I am sometimes unable to control my behavior.

Please elaborate: _____

_____

_____

_____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

_____

_____

_____

_____

www.TexasPCS.org
(972) 895-2502
Support@TexasPCS.org

Please list your therapy goals:

_____

_____

_____

_____

_____

_____

_____

Signature

Date

Printed Name