Centers for Family Change: ADULT INFORMATION FORM

Name_____ Date_____

Date of Birth_____ Age_____ Gender_____

MEDICAL HISTORY

Name of Primary Care Physician_____

Physician's Address_____

Physician's Phone_____ Date of last medical evaluation_____

Current health problems:_____

Current medications: _____

Have you ever been hospitalized for psychiatric reason? (Circle One) YES / NO
Please list year and reason for hospitalization: _____

_____

Have you ever had any previous outpatient psychotherapy? YES / NO
If yes, please list year and name of therapist: _____

_____

Do you use recreational drugs? YES NO If no, have you used previously? YES / NO
If you are no longer using drugs, when did you stop? _____
What types of drugs do you/have you used? _____
_____

Circle the statement that describes your current alcohol use (for the past year):

Never drink	1 drink a day	2-3 drinks a day
2-4 times a month	4 or more drinks a day.	

Have you ever had a blackout due to excessive alcohol use? YES / NO
Have you ever received a DUI? YES / NO

Do you smoke cigarettes? YES NO
Do you use other forms of tobacco? YES NO If yes, what kind? _____

Do you have any relatives (children, parents, grandparents, aunts/uncles) who have experienced depression, anxiety or other emotional difficulties? Please list & note type of disorder:

_____
_____

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BACKGROUND INFORMATION

Please check all information that applies to your biological parents:

MOTHER		FATHER	
	_____ living		_____ living
	_____ deceased		_____ deceased
	_____ married		_____ married
	_____ divorced		_____ divorced
	_____ remarried _____ # of times		_____ remarried _____ # of times

How many siblings do you have? _____ How many step-siblings/half-siblings? _____

Education/Occupational Information :
What was the highest level of education completed? _____

Did you experience any developmental, academic or behavioral problems as a child? YES NO
Please specify if yes: _____

Current Occupation:_____

Current Employment: _____

Have you ever been fired from a job? Yes/ No
Reasons for termination: _____

Marital History
Marital status: ____ Never married ____ Married ____ Separated _____ Divorced_____ Widowed

What year were you married? _____ Spouse's name: _____

Have you been married previously? Y/N If yes, years of previous marriage: _____

Ages of children: _____

Legal Concerns
Any current Legal issues? Yes/No If Yes, please describe: _____

_____