FORENSIC COUNSELING SERVICES

Aaron Robb, Ph.D., LPC-S

Program Director

Mailing address:
2831 Eldorado Pkwy, Ste. 103-377, Frisco, TX 75033

Telephone: 972-360-7437
Fax: 940-343-2601

Interview offices in Frisco and Lewisville

www.texascounseling.org

ADULT INFORMATION FORM

Name_____ Gender: _____

Date of Birth _____ Age _____ Date completed: _____

MEDICAL HISTORY

Name of primary care physician: _____

Address: _____

Phone: _____ Fax: _____

Last medical evaluation (date):_____ Next appointment (date): _____

Other physicians you see:

Name: _____ Reason: _____

Name: _____ Reason: _____

Current medications being taken (use additional pages if needed):

Medication name	Dosage and Frequency	Start Date	Purpose

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital name/address	Date	Reason

Have you ever been in counseling/therapy for any reason? (Circle one) YES NO

Counselor/therapist name/address	Date	Reason

Recreational drug use/experimentation history:

Type of drug	How much	How often	Last use

Any alcohol use currently? (Circle one) YES NO Any past use? (Circle one) YES NO

If yes to either, what kind/how much? _____

Any tobacco use currently? (Circle one) YES NO Any past use? (Circle one) YES NO

If yes to either, what kind/how much? _____

Describe any other health problems or important medical history about you or your immediate family members and close relatives, including chronic ailments, depression, anxiety, or other emotional difficulties: _____

_____

_____

_____

_____

_____

_____

SCHOOL AND FAMILY HISTORY

Past and current school names/locations	Dates of attendance	Degree/Last grade completed

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain:

_____

_____

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

_____

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

_____

_____

Please check all information which applies to your parents and other persons who raised you:

Biological Mother	Biological Father	Other Who:_____	Other Who: _____
___ living	___ living	___ living	___ living
___ deceased	___ deceased	___ deceased	___ deceased
___ married	___ married	___ married	___ married
___ divorced	___ divorced	___ divorced	___ divorced
___ remarried	___ remarried	___ remarried	___ remarried

Where do these people live currently: _____

Describe your relationship with your mother while growing up: _____

_____

Currently:_____

_____

Describe your relationship with your father while growing up: _____

_____

Currently:_____

_____

Describe your relationship with others who raised you while growing up: _____

_____

Currently:_____

_____

Your brothers & sisters:

Name	Age	Relationship (same parents, stepsibling, halfsibling, etc.)

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: _____

_____

Sexual/physical/emotional abuse: _____

_____

Law enforcement (convictions, arrests, criminal involvement): _____

_____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced

___Widowed ___Living w/someone ___ Other: _____

If currently married, when were you married? _____

If living with someone, for how long? _____

Please list your children:

Name	Age	Relationship (biological, step, etc.)	Parenting time / residence schedule

If you are currently going through a divorce or other litigation please provide the following

Your Attorney's Name: _____

Address: _____
Street City State Zip Code

Telephone Number: _____ Fax Number: _____

DAY TO DAY FUNCTIONING

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry

____ashamed ____aggressive ___resentful ____worthless ___tearful ____irritable

____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had that concern you: _____

_____

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 explain: _____

Do you participate in regular exercise? (Circle One) YES NO

Have you had any change in eating or sleeping habits? (Circle One) YES NO

If yes, please describe: _____

_____

What activities or hobbies do you participate in? _____

_____

Describe your current working environment: _____

_____

List any adult involvement with law enforcement (current or past convictions, arrests, criminal involvement, etc.): _____

_____

Have you ever **considered suicide**

- in connection to your **current** problems? (Circle One) YES NO

  If yes, please describe when and what you considered: _____

  _____

- in the **past**? (Circle One) YES NO

  If yes, please describe when and what you considered: _____

  _____

Have you **attempted** suicide recently or in the past? (Circle One) YES NO

If yes, please describe when and what you tried: _____

_____

Have you had any thoughts of **hurting others**

- recently or in regard to your **current** problems? (Circle One) YES NO

  If yes, please explain: _____

- in the **past**? (Circle One) YES NO

  If yes, please explain: _____

CURRENT CONCERNS AND GOALS

Please note any current impediments or problems in daily emotional, social or occupational functioning (e.g. isolation from friends/family, difficulty completing daily tasks, financial strain, recent divorce, problems at work, etc.) or other information you would like to share:

_____

_____

_____

_____

_____

_____

What are your goals for therapy: _____

_____

_____

_____

_____

_____