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## FORENSIC COUNSELING SERVICES

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### ADULT INFORMATION FORM

Name \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date completed: \_\_\_\_\_

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### MEDICAL HISTORY

Name of primary care physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Last medical evaluation (date): \_\_\_\_\_ Next appointment (date): \_\_\_\_\_

Other healthcare professionals you see:

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

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: _____
<input type="checkbox"/> living	<input type="checkbox"/> living	<input type="checkbox"/> living	<input type="checkbox"/> living
<input type="checkbox"/> deceased	<input type="checkbox"/> deceased	<input type="checkbox"/> deceased	<input type="checkbox"/> deceased
<input type="checkbox"/> married	<input type="checkbox"/> married	<input type="checkbox"/> married	<input type="checkbox"/> married
<input type="checkbox"/> divorced	<input type="checkbox"/> divorced	<input type="checkbox"/> divorced	<input type="checkbox"/> divorced
<input type="checkbox"/> remarried	<input type="checkbox"/> remarried	<input type="checkbox"/> remarried	<input type="checkbox"/> 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): \_\_\_\_\_

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### 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: \_\_\_\_\_

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### 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_