## ADULT Information Gathering Form

If you would like to save valuable session time, please print and complete this form. Answer the questions to the best of your knowledge. If there are any questions that make you uncomfortable or you are unsure about, simply skip it. NOTE: the information you provide is confidential and will not be shared.
PLEASE PRINT. THANK YOU.

Name: _____
Last First Middle

Home Address: _____ City & State: _____ Zip: _____

Date of Birth: ____/____/_____ Age: _____

Highest Level of Education: _____ Additional Language/s: _____

Employed ___ Y ___ N Occupation: _____ Length Employed: _____

Phone: _____ Alt Ph: _____ May we leave a message? ___ Y ___ N

Email address: _____ May we email you? ___ Y ___ N

NOTE: Email is not a 'secure and confidential' form of communication.

Emergency Contact Individual:

Name: _____ Relationship: _____ Phone # _____

### Reason for Seeking Counseling

What it is that brings you to counseling at this specific time in your life?

_____

_____

_____

How have you dealt with this in the past and how did that work?

_____

_____

_____

Is there anything that you recognize as making the problem / issue worse at specific times?

_____

_____

_____

Do you have specific changes you want to achieve with counseling?

_____

_____

_____

Recent significant life changes or stressful events in your life: _____

_____

_____

## General Health Information

1. **Have you ever received any type of mental health services in the past?** (Counseling, psychotherapy, psychiatric services, in-patient or out-patient substance abuse) ___ Y ____ N

If yes, Please specify When: _____ How Long: _____ Why: _____

Where or with whom: _____

May we contact for information? ___ Y ___ N

2. **Are you currently taking any prescription medications?** If so, complete below information: (approx)

| Name of medication | Dosage & x's per day | When began | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

3. **How would you rate your current physical health?** (check most appropriate)

___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___ Excellent

What accounts for the rating you selected? _____

4. **Please list any specific or chronic health problems** (inc pain) you have been experiencing, if any.

_____

What are you doing to deal with the health problem? _____

5. **Please rate your current sleeping habits:**

___ Poor ___ Unsatisfactory ___ Satisfactory ___ Good ___ Very Good ___ Excellent

What accounts for the rating you selected? _____

6. **How many times (if at all) do you exercise in a week?** _____

Average length of time: _____ Since When? _____ Rate your enjoyment of exercise, 1-10 : _____

What type of exercise do you engage in: _____

7. **What meals do you typically eat on a daily basis and approximate time of day eaten?**

___ breakfast _____am or pm / ___ lunch _____ am or pm / ___ dinner _____ am or pm

___ snacks ____ times a day ~ Most during ___ day ___ night Types: _____

## Mental Health Information

1. **Are you currently experiencing overwhelming sadness, grief, or depression?** ___ Y ___ N

Which if any: _____ How many times a day? _____ How many hours a day? _____

When began: _____ Can you name what it may be connected to?

_____

_____

What, if anything, do you do to help yourself? How much does it help? _____

_____

2. **Are you currently experiencing any:** anxiety, panic attacks, or phobias? ___ Y ___ N

If yes, which one and what are your symptoms? _____

_____

When did they start: _____ On a scale of 1 to 10 please rate the severity _____

If you know – what is the trigger? _____

Has anything helped to reduce the symptoms and if so what? ___ Y ___ N _____

_____

**Alcohol and Substance Use**

1. **Please indicate how often you have a drink that contains alcohol?**

___ Never ___ Once a mo. or less ___ 2-4 / month ___ 2-4 / week ___ More than 4 / week

On a typical day that you are drinking, how many drinks containing alcohol do you consume?

___ 1 or 2 ___ 3 or 4 ___ 5 or 6 ___ 7 to 9 ___ 10 or more

What type of alcohol do you prefer to drink? _____ Typical ounces per drink: _____

2. **Do you use marijuana or other "recreational" drugs?** ___ Y ___ N Provide names, typical amount and frequency: _____

_____

How often? _____ Have you received treatment in the past? ___ Y ___ N When: _____

At what age did you first use? _____ Have you ever stopped? _____ For how long? _____

3. **Do you currently use any tobacco products?** ___ Y ___ N At what age did you start: _____

Product: _____ How much per day: _____ Have you ever quit? ___ Y ___ N

**Process Addictions**

Please indicate any behavior listed below that has caused problems in your life: ___ None

___ Sex ___ Gambling ___ Eating ___ Religion ___ Pornography ___ Internet

Problem created due to addiction: _____

_____

I want to change this behavior ___ Y ___ N Desire to change on a scale of 1 to 10: _____

**Relationship and Family Information**

1. **Which describes you at this time:** (Check all that apply) ___ Never Married ___ Married ___ Divorced

___ Widowed ___ Separated ___ Engaged ___ Living Together ___ Same Sex Partner

If currently in a relationship, for how long? _____ On a scale of 1 to 10 rate your satisfaction: _____

What contributes to that rating? _____

_____

What do you like best about your relationship? _____

What do you like least about your relationship? _____

**2. If you have any children from this relationship or another, please provide the following:**

| First & Last Name | Age & Sex | Where Living |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

3. Please provide name, relationship and age of anyone else living with you: _____

_____

4. Please list any siblings, their age and the quality of your relationship with them. _____

_____

_____

**Family Mental Health History:**

1. Please indicate below if there is a family history of any of the following conditions by checking yes or no for each one. If yes, provide family member relationship (father, mother, sister, grandmother, etc).

| Condition | Yes | No | Relationship |
|---|---|---|---|
| Alcohol or Substance abuse | | | |
| Anxiety | | | |
| Depression | | | |
| Domestic Violence | | | |
| Eating Disorders | | | |
| Obesity | | | |
| Obsessive Compulsive Behavior | | | |
| Schizophrenia | | | |
| Suicide Attempts | | | |
| Bi-Polar | | | |
| Other: | | | |

2. Please list any family members, friends, support groups, or community groups that are helpful to you.

_____

_____

3. **Please indicate if you have experienced any of the following abuse:**

___ Emotional ___ Sexual ___ Physical If so, at what age: _____ For how long: _____

How did it effect you? _____

4. **Has a family member or close friend committed suicide?** ___ Y ___ N Who:

_____

5. **Have you been having thoughts of harming yourself?** ___ Y ___ N Someone else? ___ Y ___ N

If another, who? _____ Do you have access to a gun or other weapon? ___ Y ___ N

6. **Is there anything else you think is important for us to know about your family** (current or childhood)**?** _____

_____

_____

**Misc. Information**

1. Please provide the following information in regard to your work, raising children, or your average day:

Do you enjoy what you are doing? ___ Y ___ N In general, do you find it stressful? ___ Y ___ N

If yes, please rate your stress on a scale of 1 to 10: ____ Is this level acceptable to you? ___ Y ___ N

What do you like MOST about it? _____

_____

What do you like LEAST about it? _____

_____

2. Do you consider yourself to be religious ___ Y ___ N spiritual ___ Y ___ N

If yes to either of these, please describe how you express this aspect of self: _____

_____

3. **If you could change just ONE thing in your personal, internal life, what would it be?**

_____

_____

**Referral Source**

How did you learn about this office? ___ Friend ____ Internet ____ Physician or other health professional ____ Other: _____

If referred by a professional or friend, may I have your permission to mention your name and thank them for the referral? ___ Y ____ No

If Yes: Name & Number: _____ Please initial here: _____

**By signing below I confirm that the above information is true and correct.**

My signature below indicates my desire and consent to participate in mental health counseling sessions and services with Maureen McLain, MS, RMHCI.

I understand that I have the right to agree to or to refuse these services at any time.

Name: (signature) _____ Printed: _____

Dated: _____