Name Date

Poyama Counseling Services

ADULT HISTORY AND CURRENT CONCERNS

FAMILY HISTORY

By whom were you primarily raised? Please circle:
Both parents Mother alone Father alone Grandparents
Mother/Stepfather Father/Stepmother Adoptive parents Other
Is your mother living/deceased? Is your father living/deceased?
If living, are they married/divorced/separated?
With whom do you have contact? Mother/Father
Did they abuse drugs? Mother: Yes/No/Unsure Father: Yes/No/Unsure
Were you separated from your parents as a child? Yes/No
Is their a history of mental or emotional problems in your family of origin? Yes/No
If yes, please describe_____
_____

Please list your Siblings (oldest first) and any others who lived with you while growing up:

Name	Age	Gender (M/F)	Name	Age	Gender (M/F)
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

Is there anything you think would be useful for me to know about your family of origin?
_____
_____
_____

DO YOU HAVE CHILDREN?

Name (oldest first)	Age/DOB	Gender (M/F)	Living at Home?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

THERAPIST'S NOTES:_____
_____
_____
_____

Name Date

DEVELOPMENTAL HISTORY:

In **your** early history:

Did you experience any prenatal, birth, or early infancy circumstances of which your therapist should be aware? _____

_____

Did you have any developmental problems, serious illness or accidents as a child? _____

_____

_____

WORK HISTORY:

Please give brief adult work history:_____

_____

_____

MARITAL/SIGNIFICANT RELATIONSHIP HISTORY:

_____ Length/Date: _____

_____ Length/Date: _____

_____ Length/Date: _____

_____ Length/Date: _____

LEGAL HISTORY:

Have you been or are you currently involved in the legal system? _____ Yes _____ No

If yes, please describe: _____

_____

THERAPY HISTORY:

Briefly state your prior experience with counseling, psychiatric hospitalization, drug or alcohol treatment:

_____

_____

Was this helpful? _____

HISTORY OF ALCOHOL OR DRUG USE:

Have you had a drug or alcohol problem in the past? _____Yes _____No

Have you been treated for a drug or alcohol problem? _____Yes _____No

Are you currently in a recovery program? _____Yes _____No

Do you currently use drugs or alcohol? _____Yes _____No

Is there a history of drug or alcohol abuse in your family of origin? _____Yes _____No

Please describe: _____

_____

_____

_____

_____

Name Date

CURRENT FUNCTIONING:

Please check any items that are a concern:

_____ Job
_____ Financial
_____ Recreation/Hobbies
_____ Partner Relationship
_____ Family of Origin
_____ Current Family Issues
_____ Relationship with Others (friend, peers, co-workers)
_____ Parenting Concerns (managing, understanding, enjoying)
_____ School
_____ Recent Loss of Death
_____ Emotional Abuse
_____ Physical Abuse
_____ Sexual Abuse
_____ Recovery Issues
_____ Alcohol
_____ Drug Use
_____ Gambling
_____ Sexuality
_____ Appetite (lack of appetite, recent weight loss or gain)
_____ Eating Disorder (anorexia, bulimia, compulsive eating, binge eating)
_____ Sleep (difficulty sleeping, sleeping too little, sleeping too much)
_____ Emotions (change quickly, hard to control, control too much, feel overwhelmed)
_____ Self-control (anger, sexual impulses, food)
_____ Anxiety (worry, fear, excessive guilt, restless, edgy)
_____ Depression (unhappiness, irritability, lack of motivation, grief, low energy)
_____ Suicidal Thoughts (past attempts, plan)
_____ Thinking (disorganized thoughts, unwanted thoughts, memory loss, trouble making decisions, obsessive thoughts)
_____ Behaviors you can't stop
_____**Please list things you feel are a strength for your life**:

_____
_____
_____

THERAPIST'S NOTES:

_____
_____
_____
_____
_____

Name Date

MEDICAL HISTORY AND INFORMATION:

How would you describe your health? Excellent Good Fair Poor (Explain)
_____

Name of your physician: _____
Are you on medication? Yes/No (circle one)

Name of medication	Dosage	Date Began	Condition

Do you have current physical symptoms (pain, headaches, fatigue, etc.? _____
_____
When was your last physical? _____

Are you concerned about any hereditary or chronic illnesses or disabling conditions?
Please describe: _____
_____

Do you exercise regularly? Yes/No Do you eat breakfast/lunch/dinner? (circle)

Do you have any allergies or adverse reactions to medications? Please describe:_____
_____
_____

Do you have any other allergies? Please describe: _____
_____

THERAPIST'S NOTES:
_____
_____
_____
_____
_____