SPAULDING PSYCHOLOGICAL SERVICES, PLLC
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ADULT INFORMATION FORM

Date: _____Patient Name: _____DOB:_____

CURRENT PROBLEMS:

Please describe your current difficulties and reason for seeking services_____

_____

_____

PLEASE CIRCLE ANY CURRENT DIFFICULTIES:

Sadness	Irritability	Anger	Anxiety	Panic Attacks
Short Attention Span	Compulsive Behavior	Obsessive Thinking	Social Withdrawal	Relationship Problems
Worry	Fatigue	Guilt	Mood Swings	Lying
Verbal Aggression	Physical Aggression	Frequent Crying	Explosive Behavior	Substance Abuse
Nightmares	Flashbacks	Hopelessness	Social Anxiety	Hyperactivity
Oppositional Behavior	Sexual Acting Out	Weight Gain	Weight Loss	Easily Embarrassed
Avoidant Behaviors	Suicidal/Homicidal Thoughts	Memory Impairment	Delayed Onset Sleep	Impulsive Behavior
Excessive Sleeping	Lack of Motivation	Insomnia	Self-Injury	Suspiciousness

Other _____

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PLEASE CIRCLE ANY RECENT OR CHRONIC STRESSORS:

Divorce	Marriage	Family Conflict	Remarriage	Birth of Child
Financial Change	Break Up of Relationship	Marital Problems	Conflict with Peers	Employment Problems
Health Problems in Family	Inadequate Financial Resources	Death of Family Member or Friend	Inadequate Housing	Health Problems
Unemployment	Arrest	Victim of a Crime	Inadequate Social Support	Other _____

MENTAL HEALTH HISTORY:

Current and/or Past Providers_____

_____

Current and/or Past Diagnoses_____

Inpatient Treatment __Yes __No If yes, when and where _____

Was past treatment helpful __Yes __ No Why_____

_____

Current Psychotropic Medications & Dosage Information __ Yes __No

If yes, list _____

Past Psychotropic Medications __Yes __No If yes, list _____

Past Suicide Attempts __ Yes __ No History of Suicidal Ideations __ Yes __ No

If yes, describe _____

CURRENT MEDICAL INFORMATION

Primary Care Physician_____ Specialists_____

Current Illnesses/Conditions_____

_____

Allergies __Yes __No If yes, list _____

Current Medications _____

_____

Height _____Weight_____ Weight Change __Yes __No If yes, describe_____

_____

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Sleep Impairment __ Yes __No If yes, describe_____

Surgeries __Yes __No If yes, list _____

Head Injuries __Yes __No If yes, describe _____

__ without loss of consciousness __ with loss of consciousness

Seizures __ Yes __No If yes, describe _____

DEVELOPMENTAL HISTORY/CHILDHOOD MEDICAL INFORMATION

Any problems with pregnancy and birth __Yes __No If yes, describe _____

_____

Developmental Delays __Yes __No If yes, describe _____

_____

Childhood illnesses/disorders (include dates and/or age)_____

_____

Other Developmental and/or Medical Information

_____

_____

History of Childhood Abuse

__Physical Abuse __Yes __No If yes, describe_____

__Sexual Abuse __Yes __No If yes, describe_____

__Emotional/Verbal Abuse __Yes __No If yes, describe _____

__Abandonment/Neglect __Yes __No Witness of Abuse? __ Yes __ No

Removed from home __Yes __No If yes, describe _____

Perpetrator of Abuse? __Yes __No If yes, describe_____

_____

FAMILY INFORMATION:

Mother_____ Educational Level_____

Occupation _____ Employer _____

Father_____ Educational Level_____

Occupation_____ Employer _____

Parents are ___Married ___Separated ___ Divorced/Year_____

___Mother Remarried ___ Father Remarried

Siblings (Name/Age)_____

Half/Step Siblings (Name/Age) _____

Raised by _____

Describe family relationships (past and current) _____

_____

Family History of

Substance Abuse __Yes __No If yes, describe _____

Mental Illness __Yes __No If yes, describe _____

Suicide __Yes __No If yes, describe _____

Violence __Yes __No If yes, describe _____

Other Family Information

_____

_____

_____

SOCIAL HISTORY:

Describe peer relationships during childhood_____

Describe current social relationships_____

Relationship with Authority __Oppositional __Compliant __Neutral __ Overly Compliant

Current Social support networks __Family __Friends __Community Organizations

Hobbies/Interests_____

Difficulty getting along with others? __ Yes __ No If yes, describe_____

_____

EDUCATIONAL HISTORY:

Educational Level_____

Special Education Services While in School __Yes __No If yes, services were based on what disability _____

Behavioral problems __Yes __ No If yes, describe _____

Repeated grades __ Yes __No If yes, what grade/s _____

Suspensions/Expulsions __Yes __No If yes, describe_____

Performance/Achievements_____

Attitude toward School_____

Strengths/Weaknesses _____

Extra-Curricular Activities _____

OCCUPATIONAL HISTORY:

__Employed FT __Employed PT __Unemployed __Retired __Disabled

Place of Employment _____Position _____

Special Training_____

Describe Job Satisfaction _____

Describe Job Performance _____

Previous Employment _____

MILITARY HISTORY:

Branch of Service_____ Duty Status_____ Length of Service_____

Discharge Type __honorable __dishonorable __medical __other than honorable

MARITAL/RELATIONSHIPS:

__Married __Single __ Widowed __Separated __ Divorced __ Long term relationship

Sexual Orientation:_____

Describe current relationship_____

Please describe previous marriages/significant relationships_____

_____

Children (include ages) _____

Custody Issues _____

Problems in Current and Past Relationships __Yes __No If yes, describe _____

_____

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SUBSTANCE USE HISTORY:

Nicotine Use __Yes __No If yes, type/s __Cigarettes __Snuff __Tobacco

Amount of Use _____ Duration of Use _____

Alcohol Use __Yes __No If yes, frequency and amount of use _____

_____

Drug Use __Yes __No If yes, drugs used _____

Past Drug Use __Yes __No If yes, drugs used_____

Frequency of Use _____

Substance Abuse Treatment __Yes __No If yes, when and where _____

History of community or social difficulties due to substance use __Yes __No

If yes, describe_____

Health Related Problems __Yes __No If yes, describe _____

_____

LEGAL HISTORY:

Pending charges __Yes __No If yes, describe _____

_____

Past Arrests __Yes __No If yes, describe _____

Convictions __Yes __No If yes, describe _____

Jail/Prison __Yes __No If yes, describe _____

Probation/Parole Officer _____

Out of Home Placements During Childhood __ Yes __No If yes, describe_____

_____

Other Information:

_____

Name of person completing form: _____

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