LifeLens Psychological and Counseling Services

Adult History Form

Account # _______________

Client Full Name: ____ **Date of Birth:** __________________

Referral source: ____

Synopsis of Presenting Problem, Symptoms, onset of symptoms: _____________________________

____

____

____

____

Education / Employment / Military Service Information

Education

	Year Graduated	Major / Course of Study	Achievement / Challenges
High School			
Associates Degree			
Under graduate			
Graduate			
Advanced			
Trade School			
Certifications			

Employment

Company Name	Dates	Primary Responsibility	Achievement / Challenges / Reason for Departure

Military Services: [ ] Yes [ ] No Combat experience: [ ] Yes [ ] No Where? _________________

Branch & Rank: ______________________________ Enlistment Date: _____________ Discharge Date: _____________

Finances:

Monthly Income: __________________________

Is Income Adequate to Meet Needs: ____

____

Financial Distress History (i.e. bankruptcy, foreclosures, repossessions, loan defaults, etc.): _______________

____

____

Cultural/Ethnic/Religioius Background:

Cultural background of parents: ____

Your cultural identification:____

Your parents' religious background: ____

Your current religious practices: ____

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Social Information

Social time is usually spent: [ ] Alone [ ] Immediate family [ ] Peers
Please describe: ____

____

Leisure & Recreational activities: ____

____

____

Has your level of activity changed? ____

Legal Information

Have you ever been charged with a crime: [ ] Yes [ ] No

Charge	Date	Alcohol / Drug Related	Disposition

Have you currently on probation or parole? [ ] Yes [ ] No

Describe: ____

Family Background Information

Current Marital Status: [ ]Single [ ]Married [ ]Divorced [ ] Separated [ ]Widowed

Marriages / Cohabitations

First ________/________/________/________/________
(age) (date) number of children separation date divorce date

Second ________/________/________/________/________
(age) (date) number of children separation date divorce date

Third ________/________/________/________/________
(age) (date) number of children separation date divorce date

Fourth ________/________/________/________/________
(age) (date) number of children separation date divorce date

Immediate Family

	Name			Sex M / F	Age	Lives with you Yes / No	Indicate if Deceased
Spouse / Partner							
Children		Bio / step / adopted	Married (M) # children				

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Family of Origin

	Name				Age	Lives with you Yes / No	Indicate if Deceased
mother							
father							
step-mother							
step-father							
siblings		Bio / step / adopted	Married (M) # children	Sex M / F			

Quality of Family Relationships

Describe interpersonal challenges in your immediate family: ____

____

____

____

____

Describe interpersonal challenges in your family of origin: ____

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____

Previous Treatment History

Dates From To	In-patient / out-patient	Mental health / substance abuse	Facility / Clinic Name

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History of Self-Injury, Suicide, Harm to Others

Self-injury yes / no if yes, please describe type(s) of self-injury, date of onset, and current pattern: ____

____

Suicidal thoughts: past yes / no; present yes / no

Suicide attempts: yes / no; if yes, please describe when and method(s): ____________________

____

____

____

Have you ever attempted to harm another person? ____

____

History of Traumatic Events (childhood abuse/neglect, sexual assaults, accidents, etc.)

Date(s)	Single incident or chronic situation	Trauma (nature of incident; people involved)

Medical History

Developmental milestones: met within normal range / associated problems (if problematic, please describe: ____

____

Accidents, Injuries, Surgeries, Allergies, Chronic Conditions: ____

____

____

____

____

Current Medications:

Medication	Dosage	Purpose	Prescriber / OTR

Chemical Use History

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Substance	Age at first use	Age at regular use	Age at last use	Amount used in last 48 hours	Amount used in last 30 days	Dependent Yes / No
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine / Crack Method:						
Heroin/Opiates Method:						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Rx Drugs						
Over-the-Counter						
Nicotine						
Caffeine						
Other						
Other						

Substance of Preference: (1) ______________________________ (2) ______________________________

Describe pattern of use (when, where): ______________________________

Describe any changes in use patterns: ______________________________

Describe mood & personality changes when using: ______________________________

Describe attempts at controlling / stopping use: ______________________________

____

Have you experienced withdrawal symptoms: yes / no

Have you experienced increased tolerance with drugs or alcohol: yes / no

Have you experienced blackouts: yes / no

Have you overdosed: yes / no If yes, describe: ______________________________

____

____

Printed Name

____ ______________________

Signature Date