Ann James
COUNSELING

Ann James Counseling, L.L.C.
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Adult Information Form

Name:_____ DOB:_____

Presenting Concern – Please describe the reason you are seeking counseling services at this time –

_____
_____
_____
_____

How would you rate the intensity of the problem or concern that led you to seek professional services?

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

Approximately how long has this concern been impacting your life?_____

Mental Health History

Please indicate symptoms you have experienced in the past 2 weeks: _____
_____
Have you sought professional mental health treatment in the past?_____
If yes, when and by whom?_____
Do you currently see a psychiatrist?_____ If yes, who? _____
Have you experienced thoughts of suicide in the past?_____ If yes, when?_____
Have you ever attempted suicide in the past?_____ If yes, when?_____
Do you have any family members who have committed suicide? _____ If yes, what relation to you? _____
Have you experienced any history of verbal/physical/sexual abuse? _____ If yes, please explain:
_____
_____
Have you experienced any other form of trauma?_____ If yes, please explain:
_____
_____

Medical History

Do you have any chronic medical conditions? _____ If yes, please list:
_____
_____

Please list current medications, dosages and prescribing physician:

_____

_____

_____

_____

_____

How often do you exercise? _____

Have you had any changes to your sleep pattern? _____ If yes, please explain: _____

_____

Have you had any changes to your appetite? _____ If yes, please explain: _____

_____

Do you use alcohol? _____ If yes, please describe the frequency of use and type: _____

_____

Do you use tobacco? _____ If yes, please describe the frequency of use and type: _____

_____

Do you use any other drugs? _____ If yes, please describe frequency of use and type: _____

_____

Have you ever been in treatment for drug or alcohol dependence? _____ If yes, please list date and place of treatment: _____

Family History

Do you have any family history of mental health concerns? _____ If yes, please explain:

_____

_____

Who currently lives in your home – please indicate ages of children? _____

_____

If married, how many years?_____ If divorced/separated, please indicate year of separation/divorce? _____

How would you describe your relationship with others in your family? _____

_____

Are there any family concerns that you would like addressed in counseling? _____ If yes, please explain:

_____

_____

Social History

What activities do you find enjoyable? _____

_____

How much time do you spend in front of a screen (i.e. television, videogames, computer)? _____

Have you experienced any legal problems? _____

Religious or Spiritual Preference _____

Educational/Occupational History

What was the last year of educational completion? _____

What is your current employment? _____

How satisfied are you with your current employment? _____

Strengths

What do you feel are your strengths?

_____
_____
_____
_____

Goals

What are your goals for therapy?

_____
_____
_____
_____

_____ _____

Client Signature Date

Reviewed by:

_____ _____

Therapist Signature Date

Treatment goals reviewed with client on _____.
Date

1.

2.

3.