LAURA LADEFIAN
COUNSELING

ADULT HISTORY FORM

Name: _____ Date of Birth: _____

Home address: _____

Phone Number: _____ Do I have permission to leave a voicemail? Yes No

Email Address: _____

Referred by: _____

Emergency Contact: _____
Name Phone
I will only contact this person if I believe it is a life or death emergency. Please sign & date to indicate that I may do so:_____

Please briefly describe the reason you have initiated counseling: _____
_____
_____
_____

What are your goals for therapy? _____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____
_____
_____

Primary Care Physician: _____ Date of last visit: _____

Current Medication(s):

Medication	Dose	Prescribing Physician	Purpose

Do you smoke or use tobacco products? If so, please share the frequency and quantity: _____
Do you consume caffeine? If so, please share the frequency and quantity: _____
Do you drink alcohol? If so, please share the frequency and quantity: _____
Do you use any non-prescription drugs? If YES, what kinds and how often?: _____
_____

Please describe your sleep, diet and exercise patterns that may impact mood and functioning:_____
_____
_____

History of hospitalization (medical or mental health):_____
_____

Have you ever been under the care of a Psychiatrist or participated in Counseling before: _____
_____
_____

Please share any previous Mental Health diagnoses and/or psychiatric medications: _____
_____
_____

Any significant family history of illness (including mental health? _____
_____

PSYCHOSOCIAL HISTORY:

What are the primary roles in your life that you feel define you? _____
_____
_____

What significant relationships in your life have had a strong impact on your personal development and how? _____
_____
_____

What events in your life have impacted you the most?_____
_____
_____
_____

Have you experienced any recent major changes in your life? _____
_____
_____

Do you have a history of trauma or abuse? _____
_____
_____

Relationship status: _____ If in a relationship, for how long? _____

Current level of satisfaction in your relationship: (Poor) 1 2 3 4 5 (Excellent)

Do you have Children?____ If YES, please share name(s) & age(s):_____
_____

List the names and ages of those living in your household: _____
_____
_____

Current level of satisfaction with your friends/social support: (Poor) 1 2 3 4 5 (Excellent)

Current level of satisfaction with your education/career: (Poor) 1 2 3 4 5 (Excellent)

Rate your relationship with technology/social media: (Poor) 1 2 3 4 5 (Excellent)

Please describe your current self-care practices:_____
_____
_____

What personal strengths do you draw from: _____
_____
_____

Please share any hobbies or significant interests in your life: _____
_____

Are there any sociocultural factors that you would like me to know about you?: _____
_____
_____

CURRENT SYMPTOMS: (Circle all that apply)

Anxiety	Depression	Anger	Headaches
Panic Attacks	Fears	Irritability	Difficulty Concentrating
Excessive Worry	Difficulty Trusting Others	Substance Abuse	Sexual Concerns
Feeling Manic	Self-Harm	Fatigue	Sleeping Too Little
Difficulty Communicating with Others	Food Restriction	Feeling Numb or Dissociated	Thoughts of Hurting Someone Else
Financial Stressors	Work/Career Stressors	Thoughts of Suicide	Sleeping Too Much
Severe Weight Gain	Severe Weight Loss	Difficulty Falling or Staying Asleep	Nightmares
Muscle Tension	Chest Pain	Nausea	Loneliness
Mood Swings	Withdrawal From Friends & Activities	Decreased Enjoyment	Feelings of Hopelessness
Crying Spells	Isolation	Binge Eating	Feeling on Edge
Restlessness	Relationship Stressors	Forgetfulness	Impulsivity

Other: _____
_____

Please share any additional information you would like for me to know about you: _____
_____
_____
_____
_____