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ADULT BACKGROUND

Name _____ Date of Birth _____

Street Address _____ City, State, Zip _____

Home/Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Emergency contact Name _____ Phone _____

Email address _____

Who referred you to Dr. Valdez?

Are you currently seeing another counselor? If so, whom?

YOUR CURRENT CONCERNS *(if not sure see list below):*

Describe briefly what led up to your calling a counselor and what you hope to get from counseling:

_____

_____

_____

Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) <u>Circle the item that you see as the most significant issue</u>)

____Adjustment to life changes (changing schools, parent's divorcing, moving, getting married or divorced, aging, etc.)
___Career Dissatisfaction or decisions
___Abuse (physical, emotional, sexual)
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling angry or irritable
___Feeling guilty or shameful
___Feeling sadness or depression or suicidal urges <u>related to grief</u>
___Feeling sadness or depression or suicidal urges <u>NOT related to grief</u>
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (repeated run-ins with the law, etc.)
___Learning/Academic difficulties
___Personal Growth (no specific problem)
___Significant other/spouse relationship
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Family or Step-family relationship
___Non-family relationship (roommates, friends, co-worker, boss, teacher, etc.)
___Religious or Spiritual concerns
___Sexual functioning concerns
___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Other (explain_____)

***Please circle the most significant issue.**

When did you first become concerned about this/these issues?
_____
_____

How have you attempted before now to deal with this issue?
Describe what things you have already done to deal with your concerns:
_____
_____

Describe the first, perhaps very small, signs that tell you things are improving:
_____
_____

PHYSCIAL HEALTH:

Current weight:_____Weight 6 months ago:_____Ideal weight:_____

Hours of sleep per night the past 2 weeks: _____ Past 6 months: _____

Kinds of exercise and number of times per week:

_____

_____

Date of last physical and name of doctor/clinic:

_____

_____

Medications you are now taking (list daily dosage and frequency):

_____

_____

_____

_____

Do you have a thyroid condition? Yes / No

Are you currently having suicidal thoughts or urges? Yes / No

Have you ever attempted suicide? Yes / No

PLAY: What do you do for fun? How many times per week?

_____

_____

_____

_____

List when you took your last vacation, with whom, what you did:

_____

_____

List when you'll take your next vacation, with whom, what you will do:

_____

_____

RELIGION: What kind of religious background, if any, were you raised in?

_____

_____

What kind of religion, if any, do you practice now?

_____
_____

MILITARY: List military experience, if any: branch of service, highest rank, years, discharge status

_____
_____

LEGAL: List dates and reasons for any arrests/criminal charges, including DWI:

_____
_____

List dates and nature of convictions:

_____
_____

List dates and places you did time in jail, prison, juvenile detention:

_____
_____

Describe any current legal concerns, including criminal, civil, custody, bankruptcy, etc.:

_____
_____

WORK: List educational degrees completed (year, institution, type of degree):

_____
_____

List trade or professional licenses/certifications:

_____
_____

What is your current job and how long have you been there? Describe briefly what you do.

_____
_____
_____
_____

FRIENDS: List the first name of one or two of your closes friends, how you came to know them, how long you have been friends, when you last talked with them.

_____
_____
_____
_____

ALCOHOL AND OTHER DRUGS List most recent use of each and how much:

Alcohol:_____

Marijuana:_____

Other drugs (specify):_____

If you have been through chemical dependency treatment, please list when and where:

Please list any 12-Step or support groups you attend per week:

LIVING SITUATION: Describe where you live, how long you've lived there, what the neighborhood is like:

_____
_____

List name, relationship to you, and age of the other people you live with:

_____
_____
_____
_____

List serious changes in health among members of your household or major ongoing health concerns:

_____
_____

List names of persons who have joined or left your household in the past 2 years (include birth, death, and adoption):

_____
_____

COMMITTED RELATIONSHIPS (if applicable): Where and when did you meet?

_____
_____
_____
_____

Describe your parents' and siblings' reaction to your partner and your relationship to him/her:

_____
_____
_____

Describe 2 strengths and 2 weaknesses in this relationship

_____
_____
_____