Phoenix Counseling Group & Play Therapy Center, LLC

Adult Client History

Please fill out this biographical background form as completely as possible. It will help me in our work together. This information is confidential. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

CLIENT NAME: ____ MALE/FEMALE: ____ DATE:__________________

DATE OF BIRTH AND BIRTHPLACE: ____ AGE: _______

OTHERS IN YOUR HOUSEHOLD:	RELATIONSHIP TO YOU:	AGE:
_____________________________	_____________________________	_____________________________
_____________________________	_____________________________	_____________________________
_____________________________	_____________________________	_____________________________
_____________________________	_____________________________	_____________________________
_____________________________	_____________________________	_____________________________
_____________________________	_____________________________	__________________________
_____________________________	_____________________________	

PRESENTING PROBLEM: (Please include symptoms, issues, when the problem started and how often it occurs)

____

____

____

____

____

____

____

____

Estimate the severity of above problem: Mild---Moderate---Severe---Very severe

CURRENT MARITAL STATUS: ____Married ____ Separated ____ Divorced ____ Live with someone

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

____

____

____
____
____

MEDICAL DOCTOR/S (name /phone): ____
____
____
____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):_____________________________
____
____
____
____
____

MEDICATION YOU ARE CURRENTLY TAKING (Please include dosage and frequency)
____
____
____
____
____
_____

NAME OF PHYSICIAN PRESCRIBING THE MEDICATION AND PHONE NUMBER: (Is the doctor your Primary Care Physician or a Psychiatrist?)
____
____
____
____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):
____
____
____
____

SUICIDE ATTEMPT(S) or SUICIDAL THOUGHTS? (describe: ages, reasons, circumstances, how, etc)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end)

1.

2.

3.

USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

____

____

____

____

____

____

____

____

IF PARENTS DIVORCED: Your age at the time: ______, Describe how it affected you at the time:

____

____

____

____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, ABUSE, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

____

____

____

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION(S), LAWSUIT(S) OR DIVORCE OR CUSTODY DISPUTE(S)? (if so, please explain):

____

____

____

____