



**ADULT INFORMATION FORM**

First Name:		MI:	Last Name:		Today's Date:
What do you prefer to be called?		SS#/Alt ID#:		Date of Birth:	Age:
Local Address:			City:	State:	Zip Code:
Permanent Address (if different from above):			City:	State:	Zip Code:
Home Phone:		May we call you here? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mobile Phone:		May we call you here? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
E-mail:		May we contact you here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Place of Employment:		Occupation:			
Work Phone:		May we call you here? <input type="checkbox"/> Yes <input type="checkbox"/> No May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list below the people with whom you live and any significant individuals in your life.					
Name		Relationship		Live with?	Age
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
				Yes/No	
Emergency Contact:		Relationship	Home Phone:		Work or Mobile Phone:
Have you had a medical examination?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of most recent: _____		Physician: _____
Have you sought counseling before?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where/when? _____		
Do you have any medical difficulties?		<input type="checkbox"/> Yes <input type="checkbox"/> No	List: _____		
Do you have any allergies?		<input type="checkbox"/> Yes <input type="checkbox"/> No	List: _____		
Are you taking any medication?		<input type="checkbox"/> Yes <input type="checkbox"/> No	List: _____		
Prescribing physician: _____					
Who suggested you come to our practice? (check all)				How did you find our contact information/phone number?	
<input type="checkbox"/> Self		<input type="checkbox"/> Roommate		<input type="checkbox"/> General Internet search (e.g., Google)	
<input type="checkbox"/> Family		<input type="checkbox"/> School/university staff		<input type="checkbox"/> Web-based Yellow Pages	
<input type="checkbox"/> Friend		<input type="checkbox"/> Counselor/therapist		<input type="checkbox"/> Paper phonebook	
<input type="checkbox"/> Physician		<input type="checkbox"/> Religious/spiritual clergy		<input type="checkbox"/> Provided by referral source	
<input type="checkbox"/> Employer		<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____	

<b>Please use your discretion and level of comfort to determine how much to respond to the questions below. We have provided a self-identify (Self-ID) option in each relevant category to allow for your unique identity to be included.</b>		
<b>Race/Ethnicity (check all):</b> <input type="checkbox"/> African American/Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Euro-American/White <input type="checkbox"/> Hispanic/Latino(a) <input type="checkbox"/> Native American <input type="checkbox"/> Self-ID: _____	<b>Relationship Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Dating <input type="checkbox"/> Partnered, not married <input type="checkbox"/> Married <input type="checkbox"/> Divorced/separated <input type="checkbox"/> Widowed <input type="checkbox"/> Self-ID: _____	<b>Sexual Identity:</b> <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian <input type="checkbox"/> Questioning <input type="checkbox"/> Self-ID: _____
<b>Gender Identity:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> MtF <input type="checkbox"/> FtM <input type="checkbox"/> Self-ID: _____	<b>Religious Affiliation/ Spiritual Identity:</b> Background: _____ Current: _____	<b>Highest level of Education:</b> _____ If applicable: Major(s) _____ Degree(s) _____
What concern(s) lead you to seek counseling? _____ _____ _____ _____		
Please check all of the following additional concerns that apply to your situation:		
<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Academic/faculty concerns <input type="checkbox"/> Adjustment/transition <input type="checkbox"/> Anxiety/worry <input type="checkbox"/> Concern about someone else <input type="checkbox"/> Depression/low mood <input type="checkbox"/> Eating disorder/body image <input type="checkbox"/> Family	<input type="checkbox"/> Fears/phobias <input type="checkbox"/> Grief/loss <input type="checkbox"/> Identity development <input type="checkbox"/> Odd/unusual experiences <input type="checkbox"/> Parenting concerns <input type="checkbox"/> Relationship problems <input type="checkbox"/> Roommate problems <input type="checkbox"/> Self-harm (e.g. cutting, burning)	<input type="checkbox"/> Self-esteem <input type="checkbox"/> Sexual assault/harassment <input type="checkbox"/> Sexuality <input type="checkbox"/> Sleep problems <input type="checkbox"/> Social life/making friends <input type="checkbox"/> Thoughts of harming self <input type="checkbox"/> Thoughts of harming others <input type="checkbox"/> Stress (e.g. work, life)
Have you ever been in trouble legally? Do you use alcohol and/or drugs? Any family history of chemical dependency? Any family history of mental illness? Have you ever been physically abused? Have you ever been sexually abused? Have you ever been emotionally abused? Have you ever experienced a traumatic event? Have you been diagnosed with a disability? Have you ever been hospitalized for psychiatric and/or substance use reasons? Have you ever seriously considered/attempted harming yourself (suicide) or someone else?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Yes <input type="checkbox"/> No   List: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No   Date(s): _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain	