southeast
Child & Family Guidance, PLLC

ADULT INFORMATION PACKET

Name: Date:

Date of Birth:

Household:

Who do you currently live with?

Name	Age	Relationship	Job/Grade

Current Concerns:

What concern brings you in?

_____

_____

When did this concern begin (give dates)?

_____

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

_____

_____

What do you hope to accomplish in counseling?

_____

_____

Treatment History:

Have you been seen by a mental health professional or received psychiatric services before?

☐No ☐Yes (If yes, please complete grid below.)

Date	Symptoms/Concern	Findings/Diagnoses	Treatments/Medications

Has anyone in your immediate family been seen by a mental health professional or received psychiatric service? If yes, please describe.

_____

_____

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicide attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Phobic avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Are there any specific behaviors, actions, habits that you would like to change?

_____

_____

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Tense
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	
Energetic	Relaxed	Hopeless	Optimistic	Jealous	Others:	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Don't like being touched
Visual disturbances	Numbness	Flushes	Hearing problems	

Biological Factors:

Do you have any current concerns about your physical health? Please specify:

_____

_____

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Medication	Dose	Reason

Please rate your use of the following:

	Never	Rarely	Often	Very Often
Alcohol				
Caffeine				
Tobacco				
Over the Counter Painkillers				
Laxatives				
Prescribed Painkillers				
Stimulants				
Cocaine/Crack				
Marijuana				
Sedatives				
Tranquilizers				
Heroin				
Hallucinogens				