

Family Guidance Center of Milford
ADULT INFORMATION FORM

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Client Name: _____ Date of Birth: _____ Age: _____
Gender: _____ Preferred Pronouns: _____

CLIENT & FAMILY HISTORY:

Reason(s) for seeking treatment: _____

Briefly describe your therapy goals: _____

Marital Status: ☐ Married ☐ Never married ☐ Separated ☐ Divorced ☐ Widowed

Household Members:

Name: _____	Age: _____	Relationship: _____	Occupation/School: _____
Name: _____	Age: _____	Relationship: _____	Occupation/School: _____
Name: _____	Age: _____	Relationship: _____	Occupation/School: _____
Name: _____	Age: _____	Relationship: _____	Occupation/School: _____
Name: _____	Age: _____	Relationship: _____	Occupation/School: _____
Name: _____	Age: _____	Relationship: _____	Occupation/School: _____

Any past or present difficulties with legal matters? ☐ No ☐ Yes (specify): _____

Is treatment court-ordered? ☐ No ☐ Yes: _____

Highest Grade Completed: ☐ High School ☐ GED ☐ College ☐ Graduate School

Employment History: ☐ Unemployed ☐ Employed ☐ Retired ☐ Disabled

If Employed: Employer name: _____ ☐ Full time ☐ Part time

How long have you worked there? _____ Are you satisfied with your job? ☐ Yes ☐ No

Military History: ☐ No ☐ Yes (branch): _____ Honorable discharge? ☐ Yes ☐ No

Do you have a religious preference? ☐ No ☐ Yes (specify): _____

MEDICAL HISTORY:

Primary Care Provider: _____ **Psychiatrist:** _____

List current medications (including over-the counter, vitamins, supplements): ☐ Check here if none

Medication: _____	Strength/Dosage: _____
Medication: _____	Strength/Dosage: _____
Medication: _____	Strength/Dosage: _____
Medication: _____	Strength/Dosage: _____
Medication: _____	Strength/Dosage: _____

Food or drug allergies: ☐ Check here if none

Allergen: _____	Reaction: _____
Allergen: _____	Reaction: _____
Allergen: _____	Reaction: _____
Allergen: _____	Reaction: _____
Allergen: _____	Reaction: _____

List any current or past medical conditions: _____

List any previous hospitalizations, surgeries, or major injuries, including dates: _____

List any family history of mental illness or substance abuse (ex: depression, alcoholism, etc): _____



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ADULT INFORMATION SHEET

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Have you received previous treatment for alcohol or drug abuse? ☐ No ☐ Yes

If yes, please list provider, reason for treatment, and dates: _____

Do you drink alcohol? ☐ No ☐ Yes (how much/how often): _____

Do you use drugs, including Nicotine? ☐ No ☐ Yes (type(s), how much/how often): _____

Have you ever thought about cutting down on your drinking or drug use? ☐ No ☐ Yes

Has anyone asked you to cut down on your drinking or drug use? ☐ No ☐ Yes

Do you get annoyed when people ask you about your drinking or drug use? ☐ No ☐ Yes

TRAUMA HISTORY:

Recent major changes/losses:

☐ Divorce/separation ☐ Change/loss of job ☐ Move/relocation ☐ Abuse
☐ Childbirth/adoption ☐ Death of loved one ☐ Health issues ☐ Other: _____

Current Symptoms (check all that apply):

☐ Anxiousness	☐ Withdrawal
☐ Tearfulness	☐ Depressed mood
☐ Irritability	☐ Difficulty concentrating
☐ Sleeplessness	☐ Mood swings
☐ Appetite changes	☐ Lack of interest in sex
☐ Hopelessness	☐ Loss of interest in usual activities
☐ Panic attacks	☐ Changes in sleep patterns
☐ Suicidal thoughts	☐ Difficulty resolving conflict/anger
☐ Decreased energy	☐ Difficulty making decisions
☐ Hyperactivity	☐ Other: _____

Have you received any previous mental health treatment? ☐ No ☐ Yes

If yes, please list provider, reason for treatment, and dates: _____

Abuse history including physical, emotional, sexual and/or exposure to domestic violence, past and present:

Have you been abusive to others? ☐ No ☐ Yes (specify): _____

Do you have any suicidal history? ☐ No ☐ Yes (specify): _____

Please add any further information you feel the therapist should know: _____

If you are interested in corresponding with your therapist by email concerning appointment scheduling ONLY, please provide your email address: _____

Client Name PRINTED

SIGNATURE

DATE