Family Guidance Center of Milford
ADULT INFORMATION SHEET

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)***:** _____
_____
_____

Have you received previous treatment for alcohol or drug abuse? ☐ Yes ☐ No
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? ☐ Yes ☐ No
Has anyone asked you to cut down on your drinking or drug use? ☐ Yes ☐ No
Do you get annoyed when people ask you about your drinking or drug use? ☐ Yes ☐ No

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

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