Lighthouse Child & Family Services

Adult Client Information Form

Today's Date ___/___/___

I. General Information

Name ____ Sex ___ Age ___ Date of Birth ____ / ____ / ____
(Please include previous names/maiden)

Status (check one): ___ Single ___ Married ___ Divorced ___ Partnered ___ Remarried ___ Separated ___ Widowed

Employment: Employer ____________________________________ Position ______________________________________

Education/Degree/Certificate(s) ____

Referred by ____

Race/Ethnic Background: ___ White ___ Black/African American ___ Hispanic/Latino ___ American Indian/Alaskan Native

___ Asian/Pacific Islander ___ Other _______________ ___ Prefer not to answer

How long have you lived in this area? ____ yrs. County of Residence ____

Are finances currently a stressor for you? Yes/No If yes, why? ____

Have you ever had any legal problems? Yes/No If yes, give date(s)/outcome(s) ______________________________________

II. Medical History

Name and address of physician/medical group ____

Last appointment with physician? ___ / ___ / ___ Reason for visit __________________________

Date of last physical (if differs from above) ___ / ___ / ___

Please list all prescription medication you are currently taking:

Name	Dosage	Prescribing Physician
________________________	___________	___________________________
________________________	___________	___________________________
________________________	___________	___________________________

Please list any over-the-counter medications you are currently taking:

Name	Dosage	Frequency	Last Use
________________________	___________	___________	____________
________________________	___________	___________	____________
________________________	___________	___________	____________

Please list any nutritional supplements (vitamins, minerals, herbal remedies):

Last Use

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Name	Dosage	Frequency	
_________________________	___________	___________	____________
_________________________	___________	___________	____________

Please list any known allergies: ____

____

Have you ever had or been diagnosed with any of the following:

	Yes	No		Yes	No
Arthritis	___	___	Asthma	___	___
Attention Deficit Disorder	___	___	Autism	___	___
Brain Injury	___	___	Breathing Problems	___	___
Cancer	___	___	Chronic Fatigue Syndrome	___	___
Chronic Pain	___	___	Diabetes	___	___
Eating Disorder	___	___	Fibromyalgia	___	___
Gastrointestinal Problems	___	___	Headaches	___	___
Heart Problems	___	___	High Blood Pressure	___	___
High Cholesterol	___	___	Lyme Disease	___	___
Menopause	___	___	Muscle Tension	___	___
Neurological Problems	___	___	Numbness	___	___
Pain in Chest	___	___	Premenstrual Syndrome (PMS)	___	___
Postpartum Depression	___	___	Seizures	___	___
Stomach Aches	___	___	Thyroid Problems	___	___
Ulcers	___	___	Other (please list) _________________________		

Any yes responses, please give date(s) and outcome(s): ____

____

List any major medical conditions in your immediate family (e.g., diabetes, cancer): ______________________________________

____

Do you drink any caffeine? Yes/No If yes, how much per day/week? ____________________

Do you drink alcohol? Yes/No If yes, how much per day/week? ____________________

Do you smoke/use tobacco? Yes/No If yes, how much per day/week? ____________________

Have you ever used recreational drugs – other than alcohol? Yes/No

If yes, please list drug and duration:

____ Have you ever had a problem with

drugs/alcohol? Yes/No **CAGE-AID:**

1. Have you ever felt you should cut down on your drinking or drug use? Yes/No
2. Have people annoyed you by criticizing your drinking or drug use? Yes/No
3. Have you ever felt badly or guilty about your drinking or drug use? Yes/No
4. Have you ever had a drink or used drugs first think in the morning to steady your nerves, or get rid of a hangover? Yes/No

III. Current Family Data (Spouse/Children/Etc.)

Please provide the following family information (including all pregnancies/adoptions):

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Name	Relationship	Age	Occupation	Resides With
____________________	___________	_____	__________________	_____________
____________________	___________	_____	__________________	_____________
____________________	___________	_____	__________________	_____________
____________________	___________	_____	__________________	_____________

Do you have immediate or extended family with a history of mental illness or chemical dependency? If so, please list below:

____

____

____

____

Do you have any history of suicide in your family? Yes/No

If so, please list member(s)/relationship: ____

IV. Employment History

	Occupation	Name of Employer	Date Employed
Present	______________	________________________	_____________
	______________	________________________	_____________
Previous	______________	________________________	_____________
	______________	________________________	_____________
	______________	________________________	_____________

V. Current Problem/History

1. Briefly state what brings you into counseling? ____

____

2. How long have you been experiencing these problems? ____

____

3. Describe how these problems affect your daily living:

Work ____

Home/Family ____

School ____

Socially/Relationships ____

Self-Care ____

Legally ____

4. What are your goals for counseling? ____

____

5. How will you know when you have achieved your goals? ____

____

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6. What are your strengths? ____

____

7. What are your hobbies? ____

____

8. Have you ever had fears of doing harm to self, others, or of losing control? Yes ____ No _____

If yes, when? ____

9. Counseling history (past and present) and/or hospitalizations:

Agency, Counselor, Hospital	Date of Service	Problem/Reason
______________________________	_______________	___________________
______________________________	_______________	___________________
______________________________	_______________	___________________

VI. Faith/Spirituality History

Please briefly describe your spiritual/faith background and its importance in your life: ____________________________________

____

Are there any other cultural concerns you have or would like us to be aware of? ____

____

VII. Miscellaneous Information

Please check all the problems/symptoms which you have experienced:

____ Depressed mood
____ Decreased appetite
____ Difficulty falling asleep
____ Sleeping too much
____ Low energy level
____ Low self-esteem
____ Difficulty concentrating or making decisions
____ Feelings of hopelessness
____ Feelings of emptiness
____ Loss of interest or pleasure
____ Feeling slowed down
____ Feeling guilty or worthless
____ Recurrent thoughts of death or dying
____ Thoughts of suicide
____ Plans of suicide
____ Attempted suicide
____ Reduced sexual interest
____ Feeling “on top of the world” without any special reason
____ Decreased need for sleep
____ Being more talkative than usual (pressure to keep talking)
____ Having racing thoughts or “flight ideas”
____ Being distractible (by unimportant or irrelevant things)
____ Being hyperactive, agitated, and “speeded up”
____ Being impulsive (overspending, sexual sprees or reckless driving)
____ Hearing a voice, even when no one else is around
____ Knowing special secrets which no one else believes
____ Having someone else read my mind or tamper with my thoughts
____ Having an outside force control my brain or thoughts
____ Using my own thought waves to control the thoughts of others
____ Seeing things that others don’t see
____ Panic attacks
____ Feeling shaky or trembling
____ Muscle aches, soreness or tension
____ Emotional abuse
____ Sexual abuse
____ Physical abuse
____ Shortness of breath/smothering sensations
____ Palpitations or accelerated heart rate
____ Sweating or cold, clammy hands
____ Dry mouth

____ Dizziness or lightheadedness
____ Nausea, diarrhea or other abnormal distress
____ Hot flashes or chills
____ Difficulty swallowing or a “lump in the throat”
____ Feeling “keyed up” or on edge
____ Exaggerated startle response
____ Irritable
____ Excessive worry
____ Flashbacks
____ Nightmares
____ Feeling detached from others
____ Feeling embarrassed in public
____ Fear of being contaminated
____ Problem gambling
____ Addiction to sex/pornography
____ Problems with self-identity/self-image
____ Needing everything to be perfect
____ Having thoughts that repeat themselves over and over
____ Feeling need to repeat certain behavior over and over
____ Being really upset about something that has happened in the last six months
____ Difficulty keeping friendships/relationships lasting
____ Losing control with anger
____ Rage - break objects
____ Rage - hit people
____ Job/occupational difficulty
____ Concerns about children
____ Crying spells
____ Inability to cry
____ Fears - list____________________________
____ Daydreaming more than usual
____ Self-injurious behavior (cutting, burning)