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

Referred by _____

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) _____

1. Briefly state what brings you into counseling? _____

_____

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

_____

3. What are your goals for counseling? _____

_____

4. How will you know when you have achieved your goals? _____

_____

5. Describe how your symptoms affect your daily living:

Work _____

Home/Family _____

School _____

Socially/Relationships _____

Self-Care _____

Legally _____

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. In the past year, have there been any changes in your life (moved, changed school/jobs, medical issues, loss of a loved one, end of relationships, etc.)? _____

_____

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

Please provide the following family information (include all pregnancies, adoptions, and foster siblings):

First Name-Last Name	Sex	Age	Relationship	Quality of Relationship (positive, neutral, negative, etc.)
1.				
2.				
3.				
4.				
5.				

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

If yes, please list member(s)/relationship: _____

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

Agency, Counselor, Hospital	Date of Service	Problem/Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Medical History

Name and address of physician/medical group _____

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

Please list all prescription medication you are currently taking including vitamins, minerals, herbal remedies, and their purpose:

Name	Dosage	Prescribing Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any known allergies: _____

_____

Do you have any medical concerns or chronic health problems (diabetes, heart conditions, seizures, asthma, cancer, head injuries, etc.)? _____

_____

Do you have any infectious diseases? ___ Yes ___ No

If Yes, please indicate the disease and medical precautions taken: _____

_____

_____

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

_____

V. Substance Use

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 bad or guilty about your drinking or drug use? Yes/No
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves, or get rid of a hangover? Yes/No

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

_____

_____

_____

IV. Employment History

Are you currently employed? ___ Yes ___ No If yes, please list current employer and length of current employment:

	Occupation	Name of Employer	Date Employed
Present	_____	_____	_____
	_____	_____	_____
Previous	_____	_____	_____
	_____	_____	_____

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? _____

_____

Is there anything else you think would be important for us to know in helping you?

_____

_____

_____

Please complete the symptom checklist on the next page

VII. Symptoms Checklists

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

Behavioral Issues
___ Aggression
___ Agitation
___ Animal abuse
___ Avoidance
___ Belligerence
___ Binge eating
___ Bullying
___ Compulsive
___ Defiant
___ Disinhibition
___ Exaggerated startle response
___ Fire setting
___ Hyperactivity
___ Hypervigilance
___ Impulsiveness
___ Isolative activities
___ Night walking
___ Overeating
___ Over-extending
___ Pleasure seeking
___ Purging
___ Refusing to eat
___ Risk taking
___ Task initiation
___ Thrill seeking
___ Withdrawing

Interpersonal Issues
___ Being misunderstood
___ Communication difficulties
___ Difficulty following directions
___ Fighting
___ Grandiosity
___ Lack of social resources
___ Low self-esteem
___ Sexual difficulties
___ Sexual disinterest
___ Social awareness difficulties
___ Social communication challenges
___ Social motivation issues

Physical Issues
___ Ambulation difficulties
___ Balance problems
___ Being overweight
___ Being underweight
___ Bumping into things
___ Dizziness
___ Excessive fatigue
___ Fine motor control difficulties
___ GI problems
___ Headaches
___ Increased heart rate/palpitations
___ Muscle weakness
___ Nausea/vomiting
___ Pain problems
___ Psychomotor retardation
___ Rapid breathing
___ Repetitive movements
___ Rocking
___ Sensory avoidance
___ Sensory sensitivity
___ Shortness of breath
___ Sleep too little
___ Sleep too much
___ Stomach aches
___ Sweating
___ Tics
___ Tremors
___ Weight gain
___ Weight loss
___ Visual disturbances

Chem. Dependency
___ Active Use
___ Cravings/Urges
___ Recently quit
___ Tolerance
___ Withdrawal symptoms

Consequences:
___ Academic
___ Health
___ Interpersonal
___ Legal

Emotional Issues
___ Anger issues
___ Anxious/Nervous
___ Apathy
___ Being easily annoyed
___ Boredom
___ Confused
___ Depression
___ Embarrassment
___ Feeling guilty
___ Feeling shame
___ Hard time coping
___ Helplessness
___ Hopelessness
___ Humiliation
___ Insecurity
___ Irritability
___ Loneliness
___ Panicky feelings
___ Powerlessness
___ Problems with jealousy
___ Sadness
___ Scared/fearful
___ Shy
___ Stressed
___ Worried

Safety/security
___ Agoraphobia
___ Being bullied
___ Being stalked
___ Being threatened
___ Having experienced trauma
___ Homicidal ideation
___ Previous suicide attempts
___ Self-harm: burning
___ Self-harm: cutting
___ Self-harm: head banging
___ Self-harm: scratching
___ Suicidal ideation

Cognitive Issues
___ Amnesia
___ Aphasia
___ Decision-making difficulties
___ Difficulty sustaining focus
___ Easily distracted
___ Irrational thinking
___ Loss of cognitive skills
___ Memory problems
___ Nightmares/night terrors
___ Obsessive thinking
___ Organizing difficulties
___ Poor judgement
___ Problem-solving difficulties
___ Racing thoughts
___ Rigidity
___ Sequencing problems
___ Tangential thinking
___ Tracking/attention problems

Family/Couples
___ Abusing others
___ Adoption difficulties
___ Arguing/fighting
___ Being abused
___ Divorce
___ Having an affair
___ Intimacy problems
___ Parenting problems
___ Partner infidelity
___ Separation or estrangement