Lighthouse Child & Family Services

ADULT INFORMATION FORM

GENERAL INFORMATION

Today's Date: _____ /_____ /_____

Client's Full Legal Name: _____ Preferred Name: _____

DOB: _____ /_____ /_____ Age: _____ Sex: _____

Referred to LCFS by: _____

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Remarried ☐ Separated ☐ Widowed

County of Residence: _____

How long have you lived in this area? _____ years _____ months

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

Briefly explain what brings you into counseling:

_____

_____

How long have you been experiencing these problems/feelings?

_____

_____

Describe how your symptoms affect your daily living in the following areas:
Work: _____
Home/Family:_____
School: _____
Socially/Relationships: _____
Self-Care: _____
Legally: _____

What are your goals for counseling?

_____

_____

How will you know when you have achieved your goals?

_____

_____

What are your strengths?

_____

_____

What are your hobbies?

_____

_____

Are finances currently a stressor for you? ☐ Yes ☐ No
If yes, please explain: _____

Have you ever had any legal problems? ☐ Yes ☐ No
If yes, please provide date(s)/outcome(s): _____

In the past year, have you experienced any major life changes (moved, changed schools/jobs, medical issues, loss of a loved one, end of a relationship, etc.)? ☐ Yes ☐ No
If yes, please explain: _____

Are there any cultural concerns you have or would like us to be aware of? ☐ Yes ☐ No
If yes, please explain: _____

CURRENT FAMILY DATA

Please provide the following information for family members you are currently residing with. Include all adoptive, step, and foster relationships. Attach an additional sheet of paper if more space is needed.

First/Last Name	Sex	Age	Relationship	Quality of Relationship (positive, neutral, negative)
1.				
2.				
3.				
4.				
5.				
6.				

MENTAL HEALTH HISTORY

Have you sought counseling services in the past? ☐ Yes ☐ No
If yes, please provide date(s)/agency: _____

Have you had any hospitalizations surrounding mental health concerns? ☐ Yes ☐ No
If yes, when and what concern? _____

Have you ever had fears of causing harm to yourself, others or of losing control? ☐ Yes ☐ No
If yes, when and what fear(s)? _____

Is there a history of suicide in your family? ☐ Yes ☐ No
If yes, what family member/date(s)? _____

Have you had any previous psychological or psychiatric treatment? ☐ Yes ☐ No
If yes, with whom, where and when: _____

Have you had any previous psychological testing? ☐ Yes ☐ No
If yes, with whom, where and when: _____

MEDICAL HISTORY

Name and city of physician/medical group: _____

Last appointment with physician: _____/_____/_____

Date of last physical: _____/_____/_____

Do you have a history of serious illness, injuries, handicaps, or hospitalizations? ☐ Yes ☐ No
If yes, please explain: _____

Do you have any infectious diseases? ☐ Yes ☐ No
If yes, list disease and medical precautions taken: _____

Are there any major medical conditions in your immediate family? ☐ Yes ☐ No
If yes, list the condition and your relationship of the family member: _____
_____

Please list all prescribed medications your child is currently taking including vitamins, minerals, herbal remedies, and its purpose:

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

Please list any known allergies: _____

SUBSTANCE USE HISTORY

Do you drink 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 recreations/street drugs (other than alcohol)? ☐ Yes ☐ No
If yes, list drug and duration: _____

Have you ever felt like you had a problem with drugs and/or alcohol? ☐ Yes ☐ No
If yes, please explain: _____

CAGE-AID

Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No
Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
Have you ever had a drink or used drugs first thing in the morning, to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No
Do you have immediate/extended family with a history of mental illness and/or substance use? ☐ Yes ☐ No
If yes, please explain: _____

FAITH/SPIRITUALITY HISTORY

If applicable, please briefly describe your spiritual/faith background and its importance in your life: _____
_____

SYMPTOM/PROBLEM CHECKLIST

Check all symptoms you are currently experiencing that are a concern to you.

1. Behavioral Issues

☐ Aggression	☐ Avoidance	☐ Bullying	☐ Disinhibition
☐ Agitation	☐ Belligerence	☐ Compulsiveness	☐ Exaggerated Startle Response
☐ Animal Abuse	☐ Binge Eating	☐ Defiance	☐ Fire Setting

☐ Hyperactivity
☐ Hypervigilance
☐ Impulsiveness
☐ Isolative Activities
☐ Night Walking
☐ Over-extending
☐ Pleasure Seeking
☐ Purging
☐ Refusing to Eat
☐ Task Initiation
☐ Thrill Seeking
☐ Withdrawing

2. Cognitive Issues

☐ Amnesia
☐ Aphasia
☐ Difficulty Making Decisions
☐ Difficulty Focusing
☐ Difficulty Organizing
☐ Difficulty Problem-solving
☐ Easily Distracted
☐ Irrational Thinking
☐ Loss of Cognitive Skills
☐ Memory Problems
☐ Nightmares/terrors
☐ Obsessive Thinking
☐ Poor Judgement
☐ Racing Thoughts
☐ Rigidity
☐ Sequencing Problems
☐ Tangential Thinking
☐ Tracking/Attention Problems

3. Emotional Issues

☐ Anger Issues
☐ Anxious/Nervous
☐ Apathy
☐ Boredom
☐ Confusion
☐ Depression
☐ Difficulty Coping
☐ Easily Annoyed
☐ Embarrassment
☐ Feeling Guilty
☐ Feeling Shame
☐ Helplessness
☐ Hopelessness
☐ Humiliation
☐ Insecurities
☐ Irritability Loneliness
☐ Jealousy Problems
☐ Panicky Feelings
☐ Powerlessness
☐ Sadness
☐ Scared/Fearful
☐ Shy
☐ Stressed
☐ Worried

4. Family/Couple Issues

☐ Abusing Others
☐ Adoption Difficulties
☐ Arguing/Fighting
☐ Being Abused
☐ Divorce
☐ Having an affair
☐ Intimacy Problems
☐ Parenting Problems
☐ Partner Infidelity
☐ Separation or Estrangement

5. Interpersonal Issues

☐ Being Misunderstood
☐ Difficulty Communicating
☐ 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

6. Physical Issues

☐ Ambulation Difficulties
☐ Balance Problems
☐ Being Overweight
☐ Being Underweight
☐ Bumping Into Things
☐ Dizziness
☐ Excessive Fatigue
☐ Excessive Sweating
☐ Fine Motor Control Difficulties
☐ Gastrointestinal Problems
☐ Headaches/Migraines
☐ Heart Problems
☐ Muscle Weakness
☐ Nausea/Vomiting
☐ Psychomotor Retardation
☐ Rapid Breathing
☐ Repetitive Movements
☐ Rocking
☐ Sensory Avoidance
☐ Sensory Sensitivity
☐ Shortness of Breath
☐ Sleeping too little
☐ Sleeping too much
☐ Stomach Aches
☐ Tremors
☐ Weight Gain
☐ Weight Loss
☐ Visual Disturbances

7. Safety/Security Issues

☐ Agoraphobia
☐ Being Bullied
☐ Being Stalked
☐ Being Threatened
☐ Homicidal Ideation
☐ Previous Suicide Attempts
☐ Self-harm: Burning
☐ Self-harm: Cutting
☐ Self-harm: Head Banging
☐ Self-Harm: Scratching
☐ Suicidal Ideation
☐ Trauma Experience

8. Substance Use Issues

☐ Active Use
☐ Cravings/Urges
☐ Recently Quite
☐ Tolerance
☐ Withdrawal Symptoms

Please list any other information you think would be important for us to know in helping you: _____

_____

_____

_____