PHA

ADULT CLIENT HISTORY

Date:_____

Please list all of the people living in your household:

Name	**Sex**	**Age**	**Place of work or school**

List any family members not living with you. (For example, grown children, former spouse):

_____

_____

What problem(s) are you experiencing at this time? _____

_____

_____

What made you decide to see a therapist now? _____

_____

_____

Describe any current medical problems, including known drug allergies, or any past major illnesses, injuries, or surgeries:_____

_____

_____

Please list the names of the medications you take, including birth control pills and vitamins.

_____

_____

Check the appropriate box describing your use of cigarettes, alcohol, and marijuana

	CIGARETTES		**ALCOHOL**		**MARIJUANA**
Don't Smoke		Don't drink		Don't smoke	
Less than 1 pack/day		Drink 1/month		Smoke 1/month	
One pack/day		Drink 1/week		Smoke 1/week	
More than 1 pack/day		Drink more than 1/week		Smoke more than 1/week	
Do you want to quit?		Do you want to quit?		Do you want to quit?	

Have you ever been arrested for DWI/PUI?_____
If so, please indicate the number of DWIs and dates_____
_____

Do you use other drugs (for example, cocaine, speed, etc.)?_____
If yes, please describe:
_____
_____

Do you have any sleep trouble?_____
If yes, check those areas that are problems:
Falling asleep___ Restless sleep____ Waking throughout the night____ Other(explain)
_____

Have your eating habits or weight changed in recent months?_____
If yes, check those areas that describe the change:
Weight loss___ Lost appetite____ Weight gain____ Increased appetite____

Have you ever seen a counselor or doctor for emotional, mental health, or substance abuse difficulties?_____
If yes, please list who and when:

_____

_____

_____

Have you ever taken any medication for emotional, mental health, or substance abuse difficulties?_____
If yes, what and when?:
_____

_____

Have you ever been in a hospital for emotional, mental health, or substance abuse difficulties?_____
If yes, for what and when?

_____

_____

Have you ever deliberately hurt yourself, overdosed, or attempted suicide?_____
If yes, how many times, when, and how?

_____

_____

_____

Have you had any feelings of wanting to hurt yourself or anyone else **over the past month**?_____
If yes, please describe:

_____

_____

Do any of your family members have emotional, behavioral, mental health, or substance abuse difficulties?____
If yes, who and what?

_____

_____

What are your personal strengths and support system that have allowed you to cope with other difficult life situations in the past?

_____

_____

_____

_____

_____

What other things would be helpful for your therapist to know to work most effectively with you?

_____

_____

_____

_____

What <u>specific</u> changes do you want to make in order to feel that your therapy experience has been successful?
1._____
2._____
3._____
4._____

Check if the following information from the Client questionnaire was reviewed:

√	**Elaborate if remarkable (e.g., include information not already presented in the Client History questionnaire)**
	Family Hx of psychiatric problems:
	Prior mental health or substance abuse Tx:
	Current medications:

Review the following as needed:

√	**Elaborate if remarkable (e.g., include information not already presented in the Client History questionnaire)**
	Educational Hx:
	Vocational Hx:
	Military Hx:
	Other: