michigan school psychological clinic

power to grow

Adult History Form

Date: _____

Name _____ Date of Birth _____ Age_____

Address _____ Phone _____ Okay to leave message on this line? ☐ Yes ☐ No

City/State/Zip _____ Email _____

Emergency contact _____ Phone _____ Email _____

Referred by _____ Relationship _____

Gender ☐ Female ☐ Male ☐ Other (specify) _____

Primary Reason for Seeking Services

☐ Anger Management	☐ Depression	☐ Mental confusion	☐ Alcohol/drugs
☐ Anxiety	☐ Eating disorder	☐ Sexual concerns	☐ Addictive behaviors
☐ Coping	☐ Fear/phobias	☐ Sleep problems	☐ Relationship issues

Briefly describe your concerns:

_____

_____

_____

_____

What are your goals for therapy/testing? _____

_____

_____

Please check if there have been any recent changes in the following:

☐ Sleep patterns	☐ Eating patterns	☐ Behavior	☐ Energy
☐ Physical activity	☐ General disposition	☐ Weight	☐ Stress

Describe changes in the areas you checked:

_____

_____

_____

Do you feel suicidal at this time: ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

ADULT PERSONAL HISTORY

Describe your Ethnicity

- ☐ Alaska Native/American Indian
- ☐ Black or African American
- ☐ Latino/a/x
- ☐ Other (specific)
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Decline to answer

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No If yes, please describe:

_____

_____

_____

Relationship Status

- ☐ Single Length of time_____
- ☐ Separated Length of time_____
- ☐ Widowed Length of time_____
- ☐ Divorce in process
- ☐ Legally married Length of time_____
- ☐ Living together Length of time_____
- ☐ Divorced Length of time_____

Assessment of current relationship (if applicable:)

- ☐ Good
- ☐ Fair
- ☐ Poor

On a scale of 1 to 10, how committed are you to staying in your current relationship? _____

Education

Highest level of education/degree _____ Type _____ Year Received _____

Military

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

Where: _____ Branch: _____ Discharge Date: _____

Employment

Currently employed: ☐ FT ☐ PT ☐ Unemployed ☐ Temp ☐ Laid off ☐ Disabled ☐ Retired ☐ Student

Begin with most recent job

Employer	# of Years	Title	Reason for Leaving

Family Information (fill out all that apply; use back page if more space is needed)

Relationship	Name	Age	Living?	Lives with you?	Indicate any history of mental health issues and type
Child			☐ Yes ☐ No	☐ Yes ☐ No	
Child			☐ Yes ☐ No	☐ Yes ☐ No	

Child			☐ Yes ☐ No	☐ Yes ☐ No	
Mother			☐ Yes ☐ No	☐ Yes ☐ No	
Father			☐ Yes ☐ No	☐ Yes ☐ No	
Sibling			☐ Yes ☐ No	☐ Yes ☐ No	
Sibling			☐ Yes ☐ No	☐ Yes ☐ No	
Sibling			☐ Yes ☐ No	☐ Yes ☐ No	

Special circumstances (for example, raised by person other than parents, information about spouse or children not living with you, stepparents, etc.)

_____

_____

_____

Social Relationships

Indicate how you generally get along with other people. Please check all that apply.

☐ Affectionate ☐ Aggressive ☐ Avoidant ☐ Leader
☐ Follower ☐ Friendly ☐ Argue/fight often ☐ Outgoing
☐ Shy/withdrawn ☐ Submissive ☐ Other (specify):

Social time is usually spent:

☐ Alone
☐ With immediate family
☐ With friends

Leisure/Recreational

Describe your specific areas of interest or hobbies

Activity	How Often Now	How Often in the Past

Religion/Spirituality

How important to you are spiritual matters? ☐ Not ☐ Little ☐ Somewhat ☐ Very

Are you affiliated with a spiritual/religious group? ☐ Yes ☐ No If yes, describe: _____

Were you raised within a spiritual/religious group? ☐ Yes ☐ No If yes, describe: _____

Legal History

Are you involved in now, or have a history of, any active traffic, civil, or criminal cases? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Are you presently on probation? ☐ Yes ☐ No

If yes, please describe:

_____
_____
_____

Developmental History

Please describe any special, unusual or traumatic circumstances that affected your development (premature birth, mother's substance use, developmental delays, etc.)

_____
_____
_____
_____
_____

History of abuse? If so, please briefly describe.

Physical: _____

Sexual: _____

Verbal: _____

Emotional: _____

Childhood issues? ☐ Abuse ☐ Neglect ☐ Inadequate nutrition ☐ Other (specify): _____

Have you ever had an experience that was so upsetting frightening that in the past month you:

Had nightmares about it or thought about it when you did not want to?	☐ Yes	☐ No
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐ Yes	☐ No
Were constantly on guard, watchful or easily started?	☐ Yes	☐ No
Felt numb or detached from others, activities and your surroundings?	☐ Yes	☐ No

Medical/Mental Health History

Physical Health History

Physician name, address, phone number: _____

_____

_____

Present/past medical care (major medical problems, surgeries, chronic illness):_____

_____

_____

Current medications and purpose: _____

_____

Mental Health History

Please indicate previous treatment

Type of Services	When	Where	Reason
Psychiatric			
Outpatient Therapy			
Inpatient Hospitalization			
Outpatient Day Treatment			
Drug/Alcohol Treatment			

Check all behaviors and symptoms that occur more than you would like:

- ☐ Aggression/anger/irritability
- ☐ Sadness
- ☐ Anxiety/panic attacks
- ☐ Hyperactivity
- ☐ Recurring disorganized thoughts
- ☐ Gambling
- ☐ Trembling
- ☐ Fatigue
- ☐ Suicidal thoughts
- ☐ Other (specify): _____
- ☐ Mood shift
- ☐ Avoiding people
- ☐ Worrying/hopelessness
- ☐ Inattention
- ☐ Memory Impairment
- ☐ Sexual difficulties/addiction
- ☐ Sick often
- ☐ Chest pain/heart palpitations
- ☐ Substance use
- ☐ Elevated mood
- ☐ Loneliness
- ☐ Phobias/fears
- ☐ Impulsivity
- ☐ Cyber addiction
- ☐ Sleeping problems
- ☐ High blood pressure

Chemical Use History

Do you have a history of substance abuse? ☐ Yes ☐ No If yes:

Have you ever felt you ought to cut down on your alcohol or substance use?	☐ Yes	☐ No
Have people annoyed you by criticizing your alcohol or substance use?	☐ Yes	☐ No
Have you ever felt bad or guilty about your substance use?	☐ Yes	☐ No
Have you ever used alcohol or substances first thing in the morning?	☐ Yes	☐ No
Do you smoke, vape or chew?	☐ Yes	☐ No
Do you use pain medication:	☐ Yes	☐ No

Please indicate below which substance you use/have used (if any)

Substance	Age of 1st Use	# days used in last 30 days	Avg. Amount Used Per Day
Alcohol			
Marijuana			
Nicotine			
Prescription Pain Meds			
Other (specify)			

How does your use impact your relationships with family and friends? _____

_____

_____

_____