DATE: ____________________

Adult Client Information Form

Please complete the following questions as best as possible. Your Therapist will review your responses with you during your session. If you need assistance, please see the Front Office Staff.

Notes:

- The completed form can either be brought to first session or emailed prior to info@fcs-midland.org
- Please bring your Insurance Card to your first session
- If you would like to apply for our sliding fee scale, you must also bring proof of household income (most recent pay stub, W-2 or Tax Returns) to the session.

Client Legal Name: ________________________ Preferred/Chosen Name: _____________________

Previous Last Name: _________________________ Date of Birth: __________________ Age: ______

Gender: She/Her He/Him They/Them Other: _________________

Sexual Orientation: ________________________

Street Address: ___________________________________ Apt # ______ City: ______________________

Mailing Address: ____ Zip Code: ___________

May letters be mailed to you? Yes No

Primary Phone Number: ___________________________ Cell Landline

May a detailed message be left? Yes No

Do you want phone appointment reminders? Yes No

Email Address: ____

Relationship Status:

Single Married Divorced Separated Widowed In a relationship Living together

Emergency Contact: _______________________ Relationship to Client: _______________________

Phone Number: ___________________________

Other person{s} authorized to make, changes, or cancel appointment{s} on client's behalf:

Name: _________________________________ Name: ___________________________________

Guardian: Yes No Name: __________________________ Phone: ________________________

May a detailed message be left with Guardian? Yes No

DATE: ____________________

Physical Health

Briefly explain your reason for seeking services, and describe what you hope to achieve in counseling.

Please check any areas you would like assistance with:

Legal	Financial	Food	Housing	Vocational	Educational
Child Care	Health Care	Counseling	Medication	Transportation	Public Assistance
Unsure	Other: ____			None	

Do you use any alternative healthcare approaches? (Check all that apply)

Yoga	Dietary Supplements	Homeopathy	Naturopathy
Acupuncture	Meditation	Massage Therapy	Traditional Healers
Movement Therapies	Relaxation Techniques	Other	

Please check any of **your** current or past health history items.

Allergies	Diabetes	Heart Disease	Asthma
Seizures	Head Injury	Sleep Problem	Chronic Pain
Headaches	Hearing Issues	Vision Issues	Cancer
Kidney Disease	Obesity	Arthritis	Stroke
High Cholesterol	Stomach Pains	High Blood Pressure	
Developmental Disability	Other: ____		

Do you have a Doctor? Yes No Doctor Name/Location:____________________________

When was the last time you saw a Doctor? ____________________ Unsure

Last approximate physical (mm/dd/yyyy): _____________________ Unsure

DATE: ____________________

Please List your current Medication/Dosage:

Provider(s):

Are you Allergic to any Medications? Yes No Unsure

If Yes, Specify: ____

Have you ever had surgery? Yes No Unsure

If yes, when and what for? ____

Are you currently pregnant? Yes No Unsure
Are you using Pre-Natal Care? Yes No Unsure

What are your current sleep patterns like (how many hours of sleep per night, trouble falling to sleep, trouble staying asleep, etc.)?

How is your current nutrition (number of meals per day, type of foods, unexpected weight loss/gain)?

Which experiences or circumstances occurred that would have interfered with normal bonding between you and your mother when you were born?

Please check all that apply:

Unsure Mother or baby left the hospital without the other

Mother delivered prematurely - delivered at _________ weeks Adoption

Medical Problems at birth with mother or baby Other None

Please check any issues your mother experienced during pregnancy:

Drug, alcohol and/or tobacco use Bleeding, infection or other medical issues

Mother did not receive regular medical care while pregnant Other None

Please describe any of your concerns about your development in infancy and/or childhood (delays, trouble walking or crawling, social issues, educational issues, etc.)

DATE: ______________________

"An 'Advance Directive' is a set instruction given by individuals specifying what actions should be taken for their health/mental health in the event that they are no longer able to make decisions due to illness or incapacity"
Do you have an Advance Directive? Yes No Unsure

Would you like more information about an Advance Directive? Yes No Unsure

Your Military History: Not Applicable Active Served During Wartime

Branch: __________________________________ Discharge Date: ______________________________

Information/Miscellaneous:

Please list other individuals in client's home- Names/Ages/Relationship:

Do you currently attend school/college/vocational training? Yes No

What is the highest level of education you have completed (Ex. K-12 grade, diploma/GED, post-secondary program, year of college, degree, etc.)? ____

If you are currently enrolled in school: Do you have an IEP? Yes No

Diagnosis: ____

Have you ever had issues in school (suspensions, truancy, etc.)? Yes No

Were these issues related to substance use? Yes No

Do you have an open Child Protective Services case? Yes No

Are you currently working? Yes Name of Employer: _____________________________________

No How long have you been without work? ___________________

Have you ever had issues in the workplace? Yes No Unsure
(work performance, Injury, attendance, fired, etc.)

DATE: ____________________

Were any of these issues related to substance use? Yes No Unsure

Do you currently have any concerns regarding your relationship? Yes No Unsure
If yes, please describe:

Do you have any siblings? Yes No How Many: _____________

Relationship with siblings: ____

Who raised you? ____

How are your current relationship/past relationships?

Everyone has strengths like patience, education, a good home or other things that they can use to help them reach their goals. Strengths are things you do well or others say you do well.
Some of my Strengths are:

Active	Family support	Independent	Resilient	Communication
Happy	Intelligent	Resourceful	Determined	Hardworking
Social	Self-Sufficient	Educated	Humorous	Musical

Other: ____

No one's life is perfect and we might have needs that brought us to FCS or that make our lives harder or keep us from reaching our goals. I need:

We all have abilities or special skills or talents like writing, arts, sports or hobbies that we are good at doing. These can make our lives better.
Some of my talents or abilities are:

Sports	TV	Video Games	Outdoor Activities	Reading
Walking	Running	Exercise	Scrapbooking	Dancing
Volunteering	Gardening	Hiking	Collecting	Art
Socializing	Music	Other: ________________		None

Has your interest or involvement in your hobbies/interests recently changed? Yes No Unsure

DATE: ______________________

Having choices or preferences makes changing or reaching goals a little easier. Choices could include things like when or where I have my appointments or whether I am part of a group or working with a counselor alone. My choices or preferences are:

Do you use social media? Yes No Unsure
If Yes, what types of social media are you using?

Do you think your use of social media is inappropriate? Yes No Unsure
If Yes, in what way ____

Who would you identify as your main support system? ____

Why? ____

What would be barriers to obtaining and using counseling services?

Do you currently have any spiritual beliefs? Yes _______________________ No Unsure

Have you, in the past, had any spiritual beliefs? Yes ________________________ No Unsure

History/Services:

Have you ever been seen by a counselor/therapist? Yes No Unsure
If yes, please describe when and where: ____

Type of service, mental health, Substance Use or both?
____

Place of Treatment: ____
Estimated Dates: ____

Have you found previous services (counseling) helpful? Yes No Unsure
Why or Why not?

DATE: ____________________

Mental Health:

Have you ever been prescribed medication to treat a mental health concern? Yes No Unsure

(Ex. Zoloft, Prozac, Campral, Antabuse, Revia, Naproxen, etc.)

Medications/Dosage/Reason for each:

Did any of these help?

Have you stayed in the hospital for mental health reasons? Yes No Unsure

When/Length of Stay/Why:

Do you have a history of suicide attempts? Yes No Unsure

Do currently or in the past used forms of self-injury (cutting, banging head against the wall) Yes No

If yes, explain: ____

Have you been previously diagnosed with a mental health disorder? (i.e. depression, anxiety, ADHD, Bipolar)

Have you or a relative been diagnosed with any of the following mental health disorders? (Please specify relative relationship, ie: Grandmother, Father, etc):

Anxiety Disorders

Bi-Polar Disorders

Behavioral Problems

Substance Use/Abuse

Other

Depressive Disorders

Psychotic Disorders

ADHD/ADD

Eating Disorders

Please describe any other non-substance additions you may experience (Ex Food, gambling, pornography. Etc.)

Do you have any past legal issues, warrants or arrests? Yes No Unsure

Do you have any current legal issues, warrants or arrests? Yes No Unsure

Are you currently working with a probation or parole officer? Yes No Unsure

Name: ______________________________________

Contact Information: ____________________________

Charges: _____________________________________

family & children's services

DATE: ______________________

What does your substance use history look like?

Substance Use History Questionnaire

Drug Category (includes nonmedical drug use)	Ever Used? Yes/No	Age of First use?	IV Use? Yes/No	Date Last Used (Ex. 2015)	Frequency of Use past 6 months	Highest Amount used
ALCOHOL						
CANNABIS: (Marijuana, Hash oil, Pot, Weed)						
STIMULANTS: Cocaine, Crack, Blow, methamphetamine-Meth, Ice, Crack						
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine, Speed, Bennies, Uppers						
BENZODIAZEPINES/HYPNOTICS/BARBITURATES: Valium, Librium, Xanax, Diazepam, Roofies, Downers, Quaalude						
HERION: Smack, Scat, Brown Sugar, Dope						
STREET OR ILLICIT METHADONE						
OTHER OPIOIDS: Tylenol #2 & #3, Percodan, Percocet, Morphine, Dilaudid						
HALLUCINOGENS: LSD, PCP, Mescaline, Peyote, Mushrooms, Ketamine, Ecstasy						
INHALANTS: Glue, Gasoline, Aerosois, Paint thinner, Poppers, Rush, Whippets						
STEROIDS: Oxandrin, Steroids, Juice						
Non-Medical USE OF PRESCRIPTION DRUGS:						
VAPING						
OTHER:						

DATE: ____________________

Have you made any efforts to reduce or abstain use? Yes No Unsure

If yes, please describe (what was the longest period without use?):

Have you ever participated in the activities while under the influence of drugs or alcohol? Yes No
Are you interested in tools and supports to help obtain/maintain? Yes No Unsure

Trauma:

If you have personally experienced any of the following, please check the corresponding box.

Nightmares	Bedwetting	Sleepwalking	Stuttering
Thumb sucking	Nail-biting	School Phobia	Fire Setting
Special Education	Sexual Abuse	Physical Abuse	Witness To Abuse
Verbal Abuse	Parents divorced	Death of Close Family member	
Domestic Violence	Neglect	Family History of Violence	
Parent Incarcerated	Self-Harm behavior	None	

Have you ever experienced and domestic partner violence? Yes No Unsure

If yes, please specify: Physical Emotional Sexual Verbal Other

Have you ever witnessed domestic partner violence? Yes No Unsure

Explain: ____

Please describe any other issues you would like to address:

*Can an Intern sit in on your sessions Yes No