Adult Clinical Information Form for Medical Record

Client's name: _____ Date of packet completion: _____
Address: _____
Phone Number (where a message can be left): (_____)_____

Emergency Contact (❒same as parent/guardian): _____Relation: _____
Address: _____
Phone Number (where a message can be left): (_____)_____

Presenting Problem:
Please briefly indicate the concern(s) that bring you into counseling at this time:_____
_____
_____

How long have you been dealing with this concern? _____

What has helped your progress? _____

What has impaired your progress? _____

What specific goals/objectives would you like to work on in therapy? Please make them about changes you would like to make not changes you'd like others to make.

1. _____
   _____
   _____
   _____
2. _____
   _____

How will you know when therapy has successfully been completed? _____
_____
_____

What do you wish your loved ones knew the most about your feelings for them and the relationship? Does anything ever get lost in translation? _____
_____

How were you referred to Better Together Counseling? Is there anyone we should thank? _____

Coping Tools/Self Care: What do you do to take care of yourself socially, physically, intellectually/mentally, creatively, emotionally, & spiritually? _____
_____

Personal Strengths: What do you like about you and/or what do others like about you? _____
_____
_____

Family:
Please tell me about who is in your current household:

Name, age, & relationship to you	Quality of relationship	Live with you full time?	Give 1-5 words that describe them
		❍Yes ❍ No	
		❍Yes ❍ No	
		❍Yes ❍ No	

		❍Yes ❍ No	
		❍Yes ❍ No	
		❍Yes ❍ No	

Please tell me about the people who you were raised with as a child (e.g. parents, significant caregivers, siblings, etc):

Name, age, relation to you	If deceased, what year?	Quality of relationship now	Quality of relationship growing up	Give 1-5 words that describe them as a person

Were you adopted or raised by someone other than your parents? ❍ Yes (at what age? _____ Were you in touch with your bio parents? _____) ❍ No

Were your parents or caregivers/people that primarily raised you: ❍ Never married and still together ❍ Never married and separated (how old were you?_____) ❍ Married and still married ❍ Married then divorced (how old were you? _____) ❍ Married now widowed (how old were you when your first parent passed? _____)❍ Never married now widowed (how old were you when your first parent passed? _____)

Quality of Your Romantic Relationship with Your Partner: ☐ N/A
Do you feel satisfied with your sexual connection with your partner? ❍Always ❍ Mostly ❍ Rarely ❍ Not at all
Please explain:_____
If there are physical problems – has there been an physical exam by a doctor? ❍Yes ❍ No

When there is tension between you and your partner do you (check all that apply): ☐ yell ☐ get critical ☐ tell my partner what they did wrong ☐ get defensive/try to explain myself ☐ follow my partner around trying to get them to talk to me ☐ ask a lot of questions ☐ point prove ☐ make threats ☐ get quite/silent ☐ get analytical ☐ tell my partner how to solve the problems ☐ leave the scene ☐ isolate ☐ stop the conversation or change the subject ☐ shut down emotionally ☐ go find something to do ☐ other: _____

Psychiatric or Substance Misuse Hospitalization/Residential Treatment Facility History: ☐ N/A.
Have you *ever* been hospitalized or received in-patient treatment for a mental health or substance abuse issue? ❍Yes ❍ No

Year	Length of Stay	Voluntary Y/N	Treatment Facility	Reason(s)
		❍Yes ❍ No		
		❍Yes ❍ No		
		❍Yes ❍ No		

Psychiatric Care: ☐ N/A.
Are you currently seeing a psychiatrist ❍Yes ❍ No – if yes, please list their name and contact information here:
_____
Do they know you are seeing me? ❍Yes ❍ No – If No, can they be informed? ❍Yes ❍ No (if yes, please sign a release)

Please inform me of your psychiatric history:

Name of Psychiatrist:	Medication RX: Dosage, Frequency:	For what diagnosis/symptoms?	Currently still taking?

			❍Yes ❍ No
			❍Yes ❍ No
			❍Yes ❍ No
			❍Yes ❍ No

Counseling:

Are you currently seeing another therapist? ❍Yes ❍ No – if yes, please list their name and contact information here:

_____

Do they know you are seeing me? ❍Yes ❍ No – If No, can they be informed? ❍Yes ❍ No (if yes, please sign a release)

Please inform me of your psychotherapeutic history:

Name of therapist	When seen (approx date) & length	For what diagnosis/symptom?

Medical:

Current non-psych meds and/or supplements	Dosage & Frequency:	Prescribed by Whom & Type of Doctor	For what diagnosis/symptom:

How do the above diagnoses affect you currently in your daily life and relationships? ☐ N/A _____

_____

Please indicate any current medical issues or symptoms that you have not told your doctor about: ☐ N/A _____

_____

Please indicate any and all medications and other substances to which you are allergic: ☐ N/A _____

_____

Please describe relevant past medical history (i.e. hysterectomy, cancer, strokes, heart attacks): ☐ N/A _____

_____

Personal History:

Please list any issues your mother had when pregnant with you or during your birth and any known developmental issues you faced as a child (e.g. delayed speech, stuttering, significant medical issues, prolonged separation from your caregiver, abuse, neglect, exposure to domestic violence, difficulty in school, etc): _____

_____

_____

Work/School (if you are in school – consider that your job):

Where do you work? _____ How long have you worked there?_____

Please check all that apply: ☐ I am well adjusted at my job ☐ I find my job distressing ☐ I feel supported at my job ☐ I ☐ I get good reviews/grades☐ I don't fit in ☐ other: _____

Family Medical History:

Please indicate any significant family medical history: ☐ N/A, ☐ cancer, ☐ cardiac disease, ☐ thyroid or endocrine problems, ☐ HBP, ☐ stroke, ☐ other: _____

Please indicate any family history of psychological symptoms or disturbances: ☐ N/A ☐ depression ☐ anxiety ☐ bipolar ☐ psychosis ☐ addiction ☐ other: _____

Substance Use:

Substance	Current Use?	Past Use?	Age of 1st use?	Age of last use?	Legal, Vocational, Medical, or Relational consequences?	Quantity of servings per week on average in last 3 months:	Do you feel it's a current problem for you?	Have you had treatment for it?
Alcohol	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Nicotine	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Pot	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Coke or Crack	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Opiates	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Benzodiazepines	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Uppers/Speed	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Crystal Meth	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Prescription misuse/abuse	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No
Other:	❍Yes ❍ No	❍Yes ❍ No			❍Yes ❍ No		❍Yes ❍ No	❍Yes ❍ No

If you have had an addiction before - how do you currently maintain your sobriety (e.g. meetings, individual therapy, etc.)? _____

If you have had an addiction before - how long have you currently been continuously clean for? _____

How did addiction affect your relationships? _____

CAGE-AID:

In the last three months, have you felt you should cut down or stop drinking or *using drugs?* ❍*Yes* ❍ *No*

In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?* ❍*Yes* ❍ *No*

In the last three months, have you felt guilty or bad about how much you drink *or use drugs*? ❍*Yes* ❍ *No*

In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*? ❍*Yes*❍ *No*

Is someone else's substance use affecting you? ❍*Yes*❍ *No*

How does their behavior affect your relationship? _____

Other addictions:

Do you currently engage in any addictive behaviors? ❍yes - please explain: _____ ❍no

Have you ever been addicted to any particular behavior before? ❍yes - please explain: _____ ❍no

What do you do stay balanced and healthy to stay away from this addictive behavior? _____

_____

How did this behavior affect your relationships? _____

Is someone else's addictive behavior affecting you? ❍*Yes*❍ *No*

How does their addictive behavior affect your relationship? _____

Risks:

Are you currently feeling like you want to hurt or kill yourself? ❍yes ❍no Do you have a plan? ❍yes ❍no

Are you currently feeling like you want to hurt or kill someone else? ❍yes ❍no Do you have a plan? ❍yes ❍no

Do you purposefully, physically hurt yourself? ❍yes ❍no – If yes – how: _____

Are you currently being abused? ❍yes ❍no If yes, by who, how & do you need help? _____

Are you currently involved in or being exposed to a relationship that contains domestic violence? ❍yes ❍no When was the last occurrence (approximate date): _____.

*Do you have a history of ANY of the previous risks listed above? ❍yes ❍no If yes, please explain & provide timelines:

_____

_____

Traumatic Events (where you have experience fear of harm or death to you or someone else): ☐ N/A

Event/What	How long ago?	If it is affecting you now – how so?

Loss History: (i.e. death of a loved one or pet, divorce, job, etc) ☐ N/A

Who/What	How long ago?	If it is affecting you now – how so?

Attachment Injury History: (i.e. affair, divorce, abuse, breaches of trust, etc) ☐ N/A

Attachment injury & approx date	By who	How it affects your relationships now:

Religious/Spiritual Orientation: ☐ N/A. Please note your orientation: _____

Sexual Orientation: _____

Military History: ☐ N/A.

Tell me about you or your family's service, experience, and how it has affected life and/or the reasons you are coming:

_____

_____

Financial:

Are you currently experiencing financial difficulties? ❍yes ❍no If yes, explain: _____

_____

How is this affecting your relationship? ☐ N/A. _____

Legal Issues:

Are you currently involved in any legal issues? ❍yes ❍no If yes, explain: _____

Do you expect to become involved in any legal issues? ❍yes ❍no If yes, explain: _____

Do you have a history of legal issues? ❍yes ❍no If yes, explain: _____

Other information about me not otherwise covered that it would be good for my therapist to know: _____

_____

_____