Adult Therapy Form

Name:______________________ Date: _____________ Race/Ethnicity: ____________________

Marital Status: Single ( ) Married( ) Separated ( ) Divorced ( ) Widowed ( )

Please list relevant dates if they apply: (marriage, separation, divorce, etc):
____

Names and ages of children (if any):
____

Reason (s) for Seeking Therapy
____
____

Do you experience any of the following: _Anger _Irritability _Tension/Stress _Fears _Tiredness _Health Issues _Use of Drugs/Alcohol _Depression _Sleep Problems _Thoughts of Suicide _Euphoria _Separation/Divorce _Worry/Anxiety _Concentration _Grief/Loss/Death _Trouble making decisions _Memory Problems _Sadness _Marital Problems _Trust Issues _Lack of Confidence _Sexual Abuse _Panic Attacks _Self-Control _Domestic Violence _Loneliness _Weight Changes

Have you been drinking alcoholic beverages in the past month? Yes __ No __ If Yes, How often? ____________ How much?_____________

Have you used drugs in the past month? (circle) Cocaine? Ice? Marijuana? Estasy? Opiates? Morphine? LSD? If Yes, How often? ___________________ How Long? _____________

Have you ever received treatment for alcohol or drug abuse? Yes __ No ___

Health Status: Do you have any physical health problems at present? _____________________

Please list all medications you are taking at the present time:
____
____

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