

ADULT HISTORY

Name _____

Please fill out the following, as completely as possible.

Birthplace	Religion	Military Service
How long have you lived in LA area?	School grade completed?	
Married? <input type="checkbox"/> Yes <input type="checkbox"/> No	How long?	

If previously married, please give dates: _____

Household members:

Name	Age	Relationship	Occupation/grade

Please list family members who have experienced or had emotional problems, psychiatric illnesses, or/and difficulties with drug or alcohol abuse

Family member (relationship to you)	Problem	Ongoing	Was the problem resolved?

Describe the Problem(s) that you are seeking help for:

How long have you struggled with this? _____

Have you ever had psychotherapy or counseling before? Yes No

If Yes, when and where? _____

Have you ever been hospitalized for psychiatric problems? Yes No

If Yes, when, where and reason? _____

Have you ever attempted suicide? Yes NO

If Yes, when, where and reason? _____

OVER

Please check the items below that describe your symptoms in the past few weeks or more

	Never	Rarely	Sometimes	Frequently	Always
1. Feel exhausted					
2. Trouble in my job					
3. Trouble concentrating					
4. I feel like crying					
5. Thoughts of suicide					
6. It's hard to have a good time					
7. I feel depressed					
8. I have trouble making decisions					
9. Planning to end my life					
10. I have trouble going to sleep					
11. It's hard to stay asleep					
12. I drink too much					
13. I use drugs too much					
14. I think about harming others					
15. Experiencing headaches or dizziness					
16. I binge eat					
17. I worry about my weight					
18. Stomach trouble					
19. Strange experiences					
20. My heart beats fast					
21. I imagine terrifying things					
22. Panicky feelings					
23. Uncontrollable worrying					
24. I fear I may harm someone					
25. I fear things I shouldn't					
26. I feel apart from people					
27. It's hard for me to make friends					
28. I have trouble keeping friends					
29. I see or hear things other people don't					
30. My mind is not as clear as it was					
31. People dislike me					
32. I get so nervous I can't move					
33. I'm afraid to go out alone					
34. I'm afraid to be alone					

MEDICAL HISTORY

When was your last physical? _____

What medications are you taking?

Medication	Frequency	Dosage

Have you had any problems with medications? _____

Recent unplanned weight gain loss How much? _____

What medical problems do you have? _____

Have you had any surgeries? Yes No

If yes, please provide dates _____

Have you had any legal difficulties? Yes No

If yes, please describe _____

Signature

Date