mountain brook wellness
3929 forest avenue
mountain brook, al 35213
p: 205.235.1277 f: 205.290.5019
www.mountainbrookwellness.com

New Client Adult Information Form

Client's name: _____ Date:_____

Form completed by (if someone other than client): _____

Gender: ____ F ____ M Date of birth: _____ Age: _____

Race/Ethnicity: _____ Religious Affiliation: _____

Primary Language Spoken: _____ Occupation/School (grade):_____

Address: _____ City: _____ State: _____ Zip: ____

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions, please use the back of the sheet.

1. Do you have any history of treatment from mental health professionals due to emotional or behavior problems? ____No ____Yes

If yes, please answer a & b.

   a. Are you currently seeing a mental health professional? ____No ____Yes
   b. How many years total have you received mental health services?
      _____

2. Have you ever been hospitalized for mental health reasons?
   ____No ____Yes Date(s): _____
   For what purpose(s): _____

3. Do you have any history of taking medications for mental health? ____No ____Yes

4. Primary reason(s) for seeking services

____Anxiety
____Crying spells
____Fears
____Hopelessness
____Irritability
____Sleeping problems
____Low motivation
____Panic attacks
____Sleeping problems
____ Trembling
____Other_____
____Other_____

____Aggression
____Depression
____Grief/Loss
____Hyperactivity
____Intrusive thoughts
____Suicidal thoughts
____Nightmares
____Restlessness
____ Sexual concerns
____ Trauma

____Concentration
____Fatigue
____Hallucinations
____Impulsive behaviors
____Lack of pleasure
____Trembling
____Obsessive thoughts
____Substance abuse
____ Suicidal thoughts

5. Check any areas in which mental health concerns are affecting your functioning.

____Emotionally
____School
____Work
____Marriage/family
____Sexually
____Other_____
____Physically
____Socially

FAMILY INFORMATION

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
Mother	_____	_____	____	____	____	____
Father	_____	_____	____	____	____	____
Spouse	_____	_____	____	____	____	____
Children	_____	_____	____	____	____	____
	_____	_____	____	____	____	____
	_____	_____	____	____	____	____

Significant others (e.g., brother, sisters, grandparents, step-relatives, half relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____
_____	_____	_____	____	____	____	____

Marital Status (more than one answer may apply)

____ Single

____ Divorce in process
Length of time: _____

____ Unmarried, living together
Length of time: _____

____ Legally married
Length of time: _____

____ Separated
Length of time: _____

____ Divorced
Length of time: _____

____ Widowed
Length of time: _____

____ Annulment
Length of time: _____

Total number of marriages: ___

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married

____ Parents have ever been separated

____ Parents ever divorced

____ Mother remarried: Number of times: _____

____ Father remarried: Number of times: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? __Yes ___ No

If Yes, please describe: _____

Has there been history of child abuse? ____ Yes ____ No

If Yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other (please specify): _____

Comments re: childhood development: _____

_____

SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all that apply)

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

____ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

____ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? ____ Yes ____ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? ____ Yes ____ No

If Yes, describe: _____

CULTURAL/ETHNIC

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

SPIRITUAL/RELIGIOUS

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: _____

LEGAL

CURRENT STATUS

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: __

_____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

PAST HISTORY

Traffic violations: ____ Yes ____ No DWI, DUI, etc.: ____ Yes ____ No
Criminal involvement: ____ Yes ____ No Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

_____

EDUCATION

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes____ No

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____
____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____

Currently: ____ FT ____ PT ____ Temp ____ Laid-off ____ Disabled ____ Retired

____ Social Security ____ Student ____ Other (describe): _____

MILITARY

Military experience? ____ Yes ____ No Combat experience? ____ Yes ____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

LEISURE/RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL/PHYSICAL HEALTH

____ AIDS
____ Alcoholism
____ Abdominal pain
____ Abortion
____ Allergies
____ Anemia
____ Appendicitis
____ Arthritis
____ Asthma
____ Bronchitis
____ Bed-wetting
____ Cancer
____ Chest pain
____ Chronic pain
____ Colds/Coughs
____ Constipation
____ Chicken pox
____ Dizziness
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Menstrual pain
____ Nose bleeds
____ Pneumonia
____ Rheumatic fever
____ Sexually transmitted diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet fever
____ Sinusitis
____ Smallpox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems
____ Vomiting

____ Dental problems ____ Miscarriages ____ Whooping cough
____ Diabetes ____ Neurological disorders ____ Other (describe): _____
____ Diarrhea ____ Nausea _____

List any current health concerns:

_____

List any recent health or physical changes:_____

_____

NUTRITION

_____

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	____ /week	_____	____ No	____ Low	____ Med	____ High
Lunch	____ /week	_____	____ No	____ Low	____ Med	____ High
Dinner	____ /week	_____	____ No	____ Low	____ Med	____ High
Snacks	____ /week	_____	____ No	____ Low	____ Med	____ High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: _____

_____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

_____

Family history of medical problems: _____

_____

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

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight

____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

SUBSTANCE USE HISTORY

_____

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	____	____	____	____
Barbiturates	_____	_____	_____	_____	____	____	____	____
Valium/Librium	_____	_____	_____	_____	____	____	____	____
Cocaine/Crack	_____	_____	_____	_____	____	____	____	____
Heroin /Opiates	_____	_____	_____	_____	____	____	____	____
Marijuana	_____	_____	_____	_____	____	____	____	____
PCP/LSD/Mescaline	_____	_____	_____	_____	____	____	____	____
Inhalants	_____	_____	_____	_____	____	____	____	____
Caffeine	_____	_____	_____	_____	____	____	____	____
Nicotine	_____	_____	_____	_____	____	____	____	____
Over the counter	_____	_____	_____	_____	____	____	____	____
Prescription drugs	_____	_____	_____	_____	____	____	____	____
Other drugs	_____	_____	_____	_____	____	____	____	____

_____

Substance of preference

1. _____ 3. _____

2. _____ 4. _____

SUBSTANCE ABUSE QUESTIONS

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

_____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? ____ Yes ____ No

If Yes, describe: _____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	_____		_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	____	____	_____	_____	_____
Suicidal thoughts/attempts	_____		_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____

Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous) ____ ____ _____ _____ _____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

____ Aggression	____ Elevated mood	____ Phobias/fears
____ Alcohol dependence	____ Fatigue	____ Recurring thoughts
____ Anger	____ Gambling	____ Sexual addiction
____ Antisocial behavior	____ Hallucinations	____ Sexual difficulties
____ Anxiety	____ Heart palpitations	____ Sick often
____ Avoiding people	____ High blood pressure	____ Sleeping problems
____ Chest pain	____ Hopelessness	____ Speech problems
____ Cyber addiction	____ Impulsivity	____ Suicidal thoughts
____ Depression	____ Irritability	____ Thoughts disorganized
____ Disorientation	____ Judgment errors	____ Trembling
____ Distractibility	____ Loneliness	____ Withdrawing
____ Dizziness	____ Memory impairment	____ Worrying
____ Drug dependence	____ Mood shifts	____ Other (specify): ____
____ Eating disorder	____ Panic attacks	_____

Briefly discuss how the above symptoms impair your ability to function effectively:

_____

_____

_____

_____

_____

_____

_____

_____

Any additional information that would assist us in understanding your concerns or problems:

_____

_____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____

_____

Do you feel suicidal at this time? ____ Yes ____ No

If Yes, explain: _____

_____

_____

_____

FOR STAFF USE

Therapist's signature/credentials: _____ Date: ____/____/_____

Therapist comments: _____

_____

_____

_____

_____

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