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Testing Information Form – Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you or you are not comfortable answering them, leave them blank.

Today's Date _____ E-Mail _____

Who referred you? _____

Name _____ Preferred name _____

Birth Sex: _____ Gender Identity: _____

Ethnic background _____ Cultural preference _____

Years of Education _____ Occupation _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Present Marital Status: _____

Family Information. Please list those in current household

Name	Age	Relationship to Client	Highest Grade of School Completed (or current grade)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

Family Stressors (check any that apply):

- Family conflicts
- Parent/Child conflicts
- Partner conflicts
- Financial problems
- Recent deaths
- Physical illness (Medical problems)
- Frequent moves
- Drug/alcohol abuse by family member
- Trauma
- Other _____

Testing HISTORY

Have you received counseling in the past? Yes No

If YES, please briefly describe _____

Name of provider: _____

Address _____

Telephone _____

Are you receiving counseling services at present? Yes No

If YES, please briefly describe:

Name of provider: _____

Address _____

Telephone _____

HISTORY OF CURRENT PROBLEMS

What brings you to testing, (please list briefly):

1. _____

2. _____

3. _____

Have you had testing in the past and if yes when? _____

Please bring a copy of testing to first appointment.

MEDICAL HISTORY

Primary Care Physician _____

Address _____

Telephone _____

When was your most recent physician visit? _____

Previous hospitalizations, surgery or major illnesses:

Dates of treatment/illness	Nature of medical problem	Outcome of condition/treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any physical concerns you have had or are having (e.g., high blood pressure, headaches, dizziness, etc.):

Are you allergic to any medication(s)? ____ Yes ____ No

If yes, please identify the medication(s):

Are you allergic to other types of allergens such as dust, mold, cats, etc.? If so, please identify.

On average, how many hours of sleep do you get daily? _____

Do you have trouble falling asleep at night? No Yes If YES, please describe.

Have you gained/lost over ten pounds in the past year? Yes No ____gained ____ lost

If YES, was the gain/loss on purpose? Yes No

Describe your appetite (during the past week):

poor appetite average appetite large appetite

Do you use caffeine? If so, explain _____

Do you or have you ever used nicotine? _____ Yes _____ No How long? _____

Is there **history** of substance abuse for alcohol or drugs? Yes No

Is there **current** substance abuse for alcohol or drugs? Yes No

Substance use/abuse (check all that apply):

- alcohol marijuana cocaine heroin/opiates
 tranquilizers hallucinogens, LSD PCP, "dust" "ecstasy"
 others: _____

What medications (and dosages) are you taking at present and for what purpose?

Medication	Dosage	Purpose

PERSONAL PSYCHIATRIC HISTORY

Have you received inpatient mental health treatment at facility? Yes No

If so, when _____ Where? _____

Please describe:

FAMILY PSYCHIATRIC HISTORY

Please indicate the presence in biological relatives of any psychiatric problem, such as depression, suicide, alcoholism, drug abuse, anxiety, panic attacks, bipolar disorder, schizophrenia, intellectual disabilities, autism spectrum disorder, learning disability, attention deficit hyperactivity disorder, childhood behavior problems, school or academic problems, narcolepsy, obsessive compulsive disorder, etc.

Please provide details about problem(s) here:

Y N N/A

Father: _____

Father's parents, brothers, sisters: _____

Mother: _____

Mother's parents, brothers, sisters: _____

Client's brothers and sisters: _____

Other biological relatives: _____

Any family history of suicide, if so, who: _____

Briefly describe your relationship with your current support system:

SYMPTOMS

Check the behaviors and symptoms that occur to you more often than you would like them to take place. Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.).

- aggression _____
- alcohol dependence _____
- anger _____
- illegal behavior _____
- anxiety _____
- avoiding people _____
- chest pain _____
- depression _____
- disorientation _____
- distractibility _____
- other _____
- dizziness _____
- drug dependence _____
- eating disorder _____
- elevated mood _____
- fatigue _____
- hallucinations _____
- heart palpitations _____
- high blood pressure _____
- hopelessness _____
- impulsivity _____
- irritability _____
- judgment errors _____
- loneliness _____
- memory impairment _____
- mood shifts _____
- panic attacks _____
- phobias/fears _____
- recurring thoughts _____
- sexual difficulties _____
- sick often _____
- sleeping problems _____
- speech problems _____
- suicidal thoughts _____
- suicidal attempts _____
- disorganized thoughts _____
- trembling _____
- withdrawing _____
- worrying _____
- other (specify) _____

List behaviors that you would like to change:

List any social difficulties:

List any difficulties at school or work:

List any difficulties at home:

List main difficulties with the thought process, i.e., memory loss, forgetfulness, etc., if any:

Additional information that you believe would be helpful _____
