

DARSHANA-LMFT

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ADULT INFORMATION FORM

Name _____ Date of 1st Appointment _____ Therapist _____
Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

- 1) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 2) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 3) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

MARITAL HISTORY

Marital status: ___ Single/never married ___ Married ___ Separated ___ Divorced ___ Widowed ___ Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

___ sad ___ anxious ___ depressed ___ frightened ___ guilty ___ angry ___ ashamed ___ aggressive ___ resentful
___ worthless ___ tearful ___ irritable ___ confused ___ extreme ups/downs ___ jealous ___ hopeless ___ helpless

Describe any other feelings you have had: _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

THOUGHTS: Please check any of the following that apply to you:

____ I sometimes hear voices even though no one nearby is talking to me.

____ I sometimes feel that forces outside of me control me.

____ I sometimes feel that other people control my thoughts.

____ I sometimes have the same thought over and over and cannot control it.

____ I sometimes feel that someone is out to hurt me or do something against me.

____ I am sometimes unable to control my behavior. Please explain: _____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!