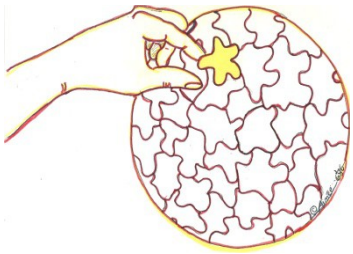

Honored Spaces Psychotherapy

Adult Information Form

(Please note that all information collected on this form is held in the strictest confidentiality.)

1.) General Information:

Name:_____/Nickmane if applicable:_____

Date of Birth:_____age:_____sex: (circle) M F other:_____

Soc. Sec #:_____/_____/_____**or** driver's License number:_____

Address:_____

street city State zip

Home Phone:_____Cell Phone #: _____***Please note any restrictions of leaving messages on any of these numbers:_____

E-mail address:_____

Are you employed? (circle) Yes No If "Yes" - please list your place of employment:

_____Length of time at this job:

_____Job hours:_____

work phone: _____May I contact you at this number? (circle) Yes No

Education level: (high school, AAS, BA, MA degree, etc)_____

2.) Payment Agreement: The hourly rate I have agreed to pay: $_____/hr

My Initials:_____ Therapists Initials:_____

3.) Referral: How were you referred you to me?

Name/Organization:_____

4.) Chief Concerns:

What concerns bring you to make this initial appointment today?

_____
_____
_____
_____

5.) Treatment History

Have you ever been seen for Drug/Alcohol/Psychiatric/Psychological treatment before?

(Please include any Psychiatric hospitalizations) _____If "yes" , When & how long? _____ For what? _____ With Whom?_____

With what results?

_____
_____

6.) **Medical:**

Please list your current Doctors where you receive medical care:

_____
_____
_____
___

When was your last medical checkup? _____

How would you rate your current health? _____

Please list any medications you are currently taking, including prescribed, vitamins, over-the-counter and herbal remedies:

Medication/drug Dose/frequency Reason you take this Prescribing Dr.

_____

_____

_____

_____

Please list any allergies/adverse medication reactions: _____

_____

_____

__

List anything else about your medical health history you would like me to know:

_____

_____

_____

___

7.) Chemical Use:

Are you a cigarette smoker? _____If so, how many packs/day or week?_____

How much beer wine, or hard liquor do you consume on average, on a weekly basis?

_____

Which drugs(non prescribed)have you used in the past 10 years? _____

_____

_____

__

Please list details on the usage of these drugs, such as, the amounts and how often used, and your reactions to these drugs/chemicals._____

_____

_____

_____

___

8.) Family of origin(the family that raised you):

Relative Name Age/or age at death Physical/Mental health or cause of death

Mother: _____

Father: _____

Siblings: _____

(list separately)_____

_____

_____

List any other information about your family that you feel would be important:_____

_____

9) Psychological/Emotional History:

Were you abused in any way(circle): Yes No Type of abuse:_____

This includes sexual(touching, molesting/fondling, intercourse), " physical (beatings, etc), neglect(not feeding, sheltering or protecting) or emotional(shame and humiliation):

Your age (at the time) Type By whom Issues resolved?

_____

_____

_____

___

Have you ever been the survivor of other types of trauma or violence? If "yes" please list:

_____

_____

_____

_____

____

Have you ever been violent towards others? If "yes" please describe:_____

_____

_____

__

Have you ever had violent thoughts towards anyone? _____If "yes" toward whom do you feel this way?

_____

Have you ever physically, sexually or emotionally abused anyone?_____ If "yes" please describe:_____

_____
_____
__

Have you ever felt suicidal? _____If "yes", when and what were the circumstances?
_____
_____
__

Have you ever attempted suicide? _____If "yes" , when and how?_____

_____

Are you feeling suicidal now?_____
Explain_____
_____
_____
__

10.) Social Information:

Please circle your current Relationship Status: Married Single Divorced Living with Partner Widowed

Spouse/Partner's Name:_____How long have you been together?____

His/Her Occupation:_____Employer:_____

Describe your relationship with your spouse/partner?_____

_____
_____
_____
_____
____

List your children's name, ages and add before child's name, "PM" for from a previous marriage, "CM", current marriage, "S" for stepchild, and "A" for adopted child, also add if they are still at home with you:

Name: age: At Home? Name: age: At Home?

_____ _____

_____ _____

_____ _____

How is your relationship with your children?_____

Please list your most social involvements(friends, church, clubs, organizations, sports, etc):_____
_____
_____

List your favorite activities, hobbies, and other interests:_____

_____
_____
_____
_____
____

What was the role of religion/spirituality in your home growing up?_____

_____

Do you have a faith preference that you practice now? _____If "yes" which church, or temple do you affiliate yourself with?_____

11.) Other:

Is there anything that as your therapist I have not addressed in this intake form, that you are wanting help and support with?_____

_____
_____
_____
___