anderson, arnold & partners L.L.P.

ADULT INFORMATION FORM

First Name:	MI:	Last Name:	Today's Date:
What do you prefer to be called?	SS#/Alt ID#:	Date of Birth:	Age:

Local Address:	City:	State:	Zip Code:
Permanent Address (if different from above):	City:	State:	Zip Code:

Home Phone:	May we call you here? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No
Mobile Phone:	May we call you here? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No
E-mail:	May we contact you here? ☐ Yes ☐ No
Place of Employment:	Occupation:
Work Phone:	May we call you here? ☐ Yes ☐ No May we leave a message? ☐ Yes ☐ No

Please list below the people with whom you live and any significant individuals in your life.

Name	Relationship	Live with?	Age	Occupation
		Yes/No		
		Yes/No		
		Yes/No		
		Yes/No		
		Yes/No		

Emergency Contact:	Relationship	Home Phone:	Work or Mobile Phone:

Have you had a medical examination? ☐ Yes ☐ No Date of most recent: _____ Physician: _____
Have you sought counseling before? ☐ Yes ☐ No If yes, where/when? _____
Do you have any medical difficulties? ☐ Yes ☐ No List: _____
Do you have any allergies? ☐ Yes ☐ No List: _____
Are you taking any medication? ☐ Yes ☐ No List: _____
_____
Prescribing physician:_____

Who suggested you come to our practice? (check all)
☐Self ☐ Roommate
☐Family ☐ School/university staff
☐Friend ☐ Counselor/therapist
☐Physician ☐ Religious/spiritual clergy
☐Employer ☐ Other:_____

How did you find our contact information/phone number?
☐ General Internet search (e.g., Google)
☐ Web-based Yellow Pages
☐ Paper phonebook
☐ Provided by referral source
☐ Other:_____

Please use your discretion and level of comfort to determine how much to respond to the questions below. We have provided a self-identify (Self-ID) option in each relevant category to allow for your unique identity to be included.

Race/Ethnicity (check all): ☐ African American/Black ☐ Asian/Pacific Islander ☐ Euro-American/White ☐ Hispanic/Latino(a) ☐ Native American ☐ Self-ID: _____	Relationship Status: ☐ Single ☐ Dating ☐ Partnered, not married ☐ Married ☐ Divorced/separated ☐ Widowed ☐ Self-ID: _____	Sexual Identity: ☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Questioning ☐ Self-ID: _____
Gender Identity: ☐ Female ☐ Male ☐ Transgender ☐ MtF ☐ FtM ☐ Self-ID: _____	Religious Affiliation/ Spiritual Identity: Background: _____ Current: _____	Highest level of Education: _____ If applicable: Major(s)_____ Degree(s)_____

What concern(s) lead you to seek counseling? _____

_____

_____

_____

Please check all of the following additional concerns that apply to your situation:

☐ ADD/ADHD	☐ Fears/phobias	☐ Self-esteem
☐ Academic/faculty concerns	☐ Grief/loss	☐ Sexual assault/harassment
☐ Adjustment/transition	☐ Identity development	☐ Sexuality
☐ Anxiety/worry	☐ Odd/unusual experiences	☐ Sleep problems
☐ Concern about someone else	☐ Parenting concerns	☐ Social life/making friends
☐ Depression/low mood	☐ Relationship problems	☐ Thoughts of harming self
☐ Eating disorder/body image	☐ Roommate problems	☐ Thoughts of harming others
☐ Family	☐ Self-harm (e.g. cutting, burning)	☐ Stress (e.g. work, life)

Have you ever been in trouble legally?	☐ Yes	☐ No		
Do you use alcohol and/or drugs?	☐ Yes	☐ No		
Any family history of chemical dependency?	☐ Yes	☐ No	☐ Uncertain	
Any family history of mental illness?	☐ Yes	☐ No	☐ Uncertain	
Have you ever been physically abused?	☐ Yes	☐ No	☐ Uncertain	
Have you ever been sexually abused?	☐ Yes	☐ No	☐ Uncertain	
Have you ever been emotionally abused?	☐ Yes	☐ No	☐ Uncertain	
Have you ever experienced a traumatic event?	☐ Yes	☐ No	☐ Uncertain	
Have you been diagnosed with a disability?	☐ Yes	☐ No	List: _____	
Have you ever been hospitalized for psychiatric and/or substance use reasons?	☐ Yes	☐ No	Date(s): _____	
Have you ever seriously considered/attempted harming yourself (suicide) or someone else?	☐ Yes	☐ No	☐ Uncertain	