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**ADULT HISTORY FORM**

Date:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity \_\_ Language \_\_\_\_\_\_\_ Sex \_\_\_\_\_ Sexual Orientation \_\_\_\_\_\_\_\_

How did you hear about me or who referred you to me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone No. (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (home)

(work)

Current Employer/Type of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the best way to contact you? \_\_ Home \_\_ Work \_\_ Cell \_\_ Text \_\_ Email

1. Describe what has recently happened that led you to seek counseling now:

2. Describe your current concerns and symptoms:

Check the one response which best applies:

(A) My current concerns and symptoms are:

\_\_ the continuation of a long-standing condition

\_\_ the reoccurrence of a previous condition

\_\_ a recent worsening of an on-going condition

\_\_ significantly different from any previous condition

\_\_ my first occurrence of any condition

HISTORY FORM

(B) My current symptoms developed:

\_\_ suddenly (less than four weeks)

\_\_ gradually (one to several months)

\_\_ very gradually (one to several years)

3. Medical History**.** Please list major injuries, illnesses or surgeries.

Condition Dates Treatment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on any medication? \_\_ Yes \_\_ No. If yes, list medications:

Medication Dosage Prescribing Physician Date Started

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you taken any psychiatric medications you have taken in the past (and are not currently taking):

Medication Dosage Prescribing Physician Date Started

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Any prior psychological history? \_\_ Yes \_\_ No

Why did you go into therapy? When? How Long? Any Medications?

What were the results?

Have you ever thought about hurting or killing yourself or hurting or killing

another person? Y/N When? \_\_\_\_\_

What were the circumstances of these experiences?

Have you ever had depression? Manic feelings? Problems with eating or

sleeping?

Ever hear things or see things that aren’t there? Ever have any confusing

thoughts?

Have you ever been hospitalized in a psychiatric facility? (Please list names of past

hospitalizations, dates, and reason for treatment.)

Hospital From/To Reason for Hospitalization

HISTORY FORM

Has anyone in your immediate or extended family had mental health issues or a psychiatric illness? Please list relationship and nature of illness.

(e.g., Mother, Father, Brothers/Sisters, Uncles/Aunts, Cousins, Grandparents

5. Drugs and Alcohol History:

Do you vape? Yes No What do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink? No Yes: 1-3 drinks/day 4-10 drinks/day

Do you smoke pot? No Yes: < 1 joint/day 2-3+ joints/day

Do you use illegal drugs? N Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? 1-2 times/day 1-2 times/week More

Drug/Alcohol Start Date Stop Date Amount/day/week

6. Family/Social/Medical History:

(Marriages, Divorce, Education, Deaths, Quality of the Relationship)

Father

Mother

Sister(s)

Brother(s)

Grandparents

Aunts/Uncles/Cousins

If your parents divorced, your age at the time: \_\_\_ Describe how it affected you:

7. Have you ever been the victim of physical, sexual or emotional trauma or abuse?

Please explain and give timeframes:

8. Is there a history of domestic violence in your home or your parent’s home?

9. Education

Highest grade Type of degree

10. Military Service Date of Discharge?

11. Arrests or convictions? (Y/N) If Yes, please explain:

HISTORY FORM

12. Family History (include yourself, parents, brother/sisters, grandparents)

√ Condition Relationship to You √ Condition Relationship to You

\_\_ Alcoholism/Drugs \_\_ Prior therapy

\_\_ Other addictions \_\_ Depression

\_\_ Cancer/Diabetes \_\_ Suicide/Attempted suicide

\_\_ Heart trouble \_\_ Legal problems

\_\_ Deaths \_\_ Divorce

\_\_ Domestic violence \_\_ Child abuse

13. Current Relationship Status

Marital status \_\_\_\_ Live with someone? Y/N Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years \_\_\_\_\_ Education of Spouse \_\_\_\_\_ Occupation of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior Marriages Years Married Prior Divorces When

Children (Names and Ages)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your current family situation and relationship history. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Occupation (former, if retired) and Employment History (use back as necessary)

15. Support System (please describe):

16. Do you exercise? What do you do?

17. What do you do to relax?

18. What would you like to do in your life?

What prevents you from doing that?

19. Are you sensitive to rejection (Y or N)

20. Do you sometimes struggle to follow directives or suggestions from someone with

authority over you? (Y or N)

21. Do you argue a lot? (Y or N)

HISTORY FORM

22. MAJOR LIFE EVENTS AND/OR CHANGES WITHIN THE LAST TWELVE MONTHS:

(Check all that apply)

Started school or training program \_\_\_

Graduated from school or training program \_\_\_

Entered job market or changed/lost job \_\_\_

Moved residence \_\_\_

Financial troubles/ Increase in financial responsibilities \_\_\_

Legal problems or arrested and/or jailed \_\_\_

Separation or divorce: self or of a friend or relative \_\_\_

Health problems (self, spouse, children) \_\_\_

Drinking or drug problems \_\_\_

Began treatment for drinking or drug problems \_\_\_

Began or ended psychotherapy \_\_\_

Began new medications \_\_\_

Significant weight gain or loss \_\_\_

Death of a significant person or pet \_\_\_

Pregnancy, miscarriage or abortion \_\_\_

Fertility problems \_\_\_

Changes in childcare \_\_\_

Children had trouble in school \_\_\_

Onset of menopause \_\_\_

Mid-life crisis \_\_\_

Victim of a crime \_\_\_

Auto accident \_\_\_

Undertaken major new expenses \_\_\_

Home repair or major addition \_\_\_

Major damage to home \_\_\_

Other (explain) \_\_\_

23. Describe your childhood growing up in your family or other circumstances

(boarding school, church school)

\_\_ My childhood was loving, safe and a good place to grow up

\_\_ My childhood was all right, we were punished when we did wrong and we were

cared for by our parents

\_\_ My childhood was OK but there was little loving and we were not allowed to talk or

express our opinion

\_\_ My childhood was tougher than others due to divorce, drugs and alcohol, a lot of

anger, yelling, and it didn’t feel that safe. My father/mother was “mean” and it had

to be his/her way, and no talking back or disagreement

\_\_ My childhood was hard: there was physical abuse, emotional abuse (and possibly

sexual abuse). It didn’t feel safe and there was no one in the family to talk to

\_\_ My childhood was very difficult, scary at times, never safe

Do you have any thoughts about how your childhood affected you and how it may still affect you in your life today?

Do you remember any early childhood trauma (e.g., parents’ separation or divorce, domestic violence, abuse of any kind, neglect or abandonment by parents, feeling left out or ignored or “not good enough.? Please explain:

Any adult trauma including physical, sexual or emotional? Please explain: