FURMAN FAMILY COUNSELING, LLC
11715 Administration Drive, Suite 101
St. Louis, Missouri 63146
(314) 993-7616

Adult History and Assessment

Today's Date: _____

A. Identification

1. Name: _____
Gender: _____ Preferred pronouns: _____
Date of birth: _____ Age:___
Nicknames or aliases: _____ Social Security number: xxx-xx- _____
Home address: _____
City: _____State: _____ Zip code: _____
Home phone: _____ Cell phone/pager: _____
E-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____
_____

2. Marital status: __ Married __Divorced __Remarried __Never married
__Other: _____

3. Spouse/Partner's name: _____ Date of birth: _____ Age: _____
Address: _____
City: _____State: _____ Zip code: _____
Home phone: _____ Cell phone/pager: _____
Spouse/partner currently employed: __ Yes __ No
Spouse/partner current employer: _____ Work phone: _____

Will your partner be attending conjoint counseling sessions? __ Yes __No

B. Employment

Currently employed: __ Yes __ No
Current employer: _____ Work phone: _____
Address: _____
_____
Calls will be discreet, but please indicate any restrictions: _____
_____

C. Referral: Who gave you my name (our agency) to call?

Name: _____ Phone: _____
Address: _____
_____

May I thank this person for the referral? __ Yes __ No
How did this person explain how I might be of help to you?_____
_____

D. Emergency Information

Emergency contact person: _____
Relationship: _____ Phone number: _____

E. Chief Concern

Please describe the main difficulty that has brought you to see me: _____
_____
_____
_____

F. Checklist of concerns

Check all that apply to you.

__ Abuse (Current emotional, physical, sexual, verbal)
__ Abuse (Past emotional, physical, sexual, verbal)
__ Aggression/violence
__ Alcohol/substance use
__ Alcohol/substance use of loved one
__ Anxiety,nervousness
__ Attention,concentration,distractibility
__Childhood issues (your own)
__ Depression, low mood, sadness
__ Divorce, separation, remarriage
__ Eating problems
__ Fatigue, tiredness, low energy
__ Financial, money issues, debt, spending
__ Gambling
__ Grieving, mourning, losses, deaths
__ Health issues, medical concerns
__ Homicidal thoughts
__ Impulsiveness, loss of control, outbursts
__ Internet issues
__ Legal matters, charges, suits
__ Marital conflict, distance, infidelity
__ Memory problems, concentration
__ Mood swings
__Obsessions, compulsions (repeated thoughts)
__ Panic attacks
__ Parenting, child management, single parent
__ Pornography use
__ Relationship problems (friends, relatives, co-workers)
__ Self-esteem
__ Self-harm/self-injurious behaviors
__ Sexual issues (dysfunctions, conflicts, sexual orientation, gender identity, sexual addictions)
__ Sleep problems – too much, too little
__ Stress, relaxation, stress management
__ Suicidal thoughts or atttempts
__ Temper problems, self-control
__ Trauma survivor or witnesss
__ Weight and diet issues
__ Work problems, employment, job dissatisfaction, unable to keep a job
__ Other (specify): _____

G. Living Environment

List all people living in the home. Indicate which children are from a previous marriage or relationship with the letter P in the last column.

Name	Relationship	Date of birth	P?

Children not living in the home:

Name	Relationship	Date of birth	P?

H. Health (Physical) History

1. Primary care doctor/clinic's name: _____
Phone: _____
Address: _____
_____

If you enter treatment with me may I contact your medical doctor so that he or she can be fully informed and we can coordinate treatment? ___ Yes ___No

2. Describe any allergies you have:

Allergen	Reaction you have	Allergy medications you take

3. List all medications, drugs, or other substances you take or have taken in the last year-prescribed, over-the-counter vitamins, herbs, and others:

Medication/drug	Dose	Taken for	Prescribed and supervised by

4. List significant illnesses, hospitalizations, medications, allergies, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures and other medical conditions:

Condition	Age	Treated by whom?	Consequences

5. Health Habits:
   a. What kinds of physical exercise do you receive? _____
   _____

   b. How much coffee, tea, cola or other sources of caffeine do you consume each day?_ _
   _____

6. Chemical Use
   a. Have you ever felt the need to cut down on your drinking? __No __Yes
   b. Have you ever felt annoyed by criticism of your drinking: __ No __ Yes
   c. Have you ever felt guilty about your drinking? __ No __Yes
   d. How much beer, wine, or hard liquor do you consume each week, on the average?_____
   e. Are there times when you drink to unconsciousness, or run out of money as a result of drinking? _____

f. How much tobacco do you smoke or chew each week? _____
g. Which drugs (not medications), substances or other chemicals have you used in the last 10 years? _____
_____
h. Which do you currently use and how often? _____

I. Mental Health/Counseling History

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before? ___ No ___Yes If yes, please indicate:

Date	Provider	Presenting problem	Results

2. Have you ever taken medications for psychiatric or emotional problems? __No __ Yes
If yes, please indicate:

Date	Provider	Medications	Presenting problem	Results

L. Personal strengths and problem areas

Personal strengths: _____
_____
Personal problem areas: _____
_____

M. Religious, racial/ethnic, sexual identification (optional)

Religious denomination/affiliation: __ Protestant __ Catholic __ Jewish __ Islamic __ Buddhist __ Hindu ___Other (specify): _____
Involvement: __ None __ Some/irregular __ Active
Ethnicity/national origin: _____ Race: _____
Sexual orientation: _____
Or other similar way you identify yourself and consider important: _____

N. Other

Is there anything else I should know that does not appear on this form that may be helpful to the counseling? _____
_____

(7/17)