

FURMAN FAMILY COUNSELING, LLC
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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 attempts
- Temper problems, self-control
- Trauma survivor or witness
- 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)