NAMASTE
COUNSELING & CONSULTATION
David R. Dagg LPCC-S, LICDC-CS

ADULT History Form

(To be filled out by the person seeking treatment)

Client's Name____

Date:__________ SS#_____-____-_____ DOB: ____/____/____ Age:____

Person completing this form: ____ Client ____Other: (give name)___________________

Who referred you to Namsate Counseling?____

What kind of help are you seeking? ____

SYMPTOM CHECKLIST: (check any symptom that you have been experiencing)

Agitated	Restless	Anxious	Appetite increase
Fearful	Worry a lot	Depressed	Appetite decrease
Cry often	Don't fit in	Confused	No appetite
Hopeless	Helpless	Sad	Self-harm thoughts/actions
Withdrawn	Desperate	Guilt	Feeling "out of control"
Suicidal	Overly tired	Distracted	Personality changes
Lose time	Hear voices	See "things"	Can't concentrate
Mood swings	Demanding	Suspicious	Impaired performance
Overactive	Rapid speech	Combative	Other:_____________
Homicidal	Angry	Aggressive	__________________
Passive	Irritable	Racing thoughts	__________________

How long have these symptoms been present? (check one)

Less than a week	One week to one month	Several months
At least a year	Several years	Since childhood

SLEEP-REST PATTERNS: (check all that apply)

Awaken early	Insomnia	Hard to get to sleep
Sleep too much	Excessive fatigue	Night terrors
Sleep walking	Nightmares	_____ # hours of sleep at night

ENERGY LEVEL: Tire easily Average energy High energy

PRIMARY STRESSORS: (Check major areas of stress)

Problems with the people counted on for support	Not enough support people
Educational stressors	Occupational stressors
Death or loss of loved one	Housing problems
Economic/financial problems	Current legal issues *
Transportation problems	Problems which relate to crime*

* Explain further: ____

Other stresors:____

TREATMENT HISTORY: (check all prior psychiatric/psychological treatment/counseling your have received)

None
Inpatient Care # of times _________
Where did this occur? ____
When did this occur? ____

Please identify where treated or who provided the following *outpatient* treatment:

Individual Outpatient therapy: ____

Group therapy: ____

Marital therapy: ____

Partial/Day Hospital: ____

Medication Management :____

School Psychologist: ____

Community Treatment Team: ____

Other: ____

CHEMICAL ABUSE/DEPENDENCY HISTORY

Have you ever felt you should cut down on your drinking? Yes No
Have people annoyed you by criticizing your drinking? Yes No
Have you ever felt bad or guilty about your dinking? Yes No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes No
Is there a history of alcohol, street drugs, and/or medication abuse/dependence?

NAMASTE
COUNSELING & CONSULTATION
David R. Dagg LPCC-S, LICDC-CS

Yes No If yes please describe:

Alcohol/Med/Drug	Age of Onset	Dose/Amount	How Often	Last Used

Do you smoke? Yes No If yes, how much? __________
Trying to quit? Yes No
Amount of caffeine consumed in a day? ____
Has there been exposure to toxic substances?_______________________________________

FAMILY HISTORY:

Describe current home living arrangements, including who is living in your home with you:

Live alone Parents Spouse/Significant Other Children
Non-Family Foster Home Group Home Nursing home/assisted living
Other : ____

Has there been exposure to abusive behaviors(s)? No Yes If yes, answer the following:
Current exposure? Past exposure? If so, when? ____________________________

Who was the abuser? ____
Type of abuse: Physical Sexual Verbal
How experienced: Personally Witnessed
Did it occur: Within the family Outside the family
Explain if present: ____

Have any other family members sought or received mental health treatment? No Yes
If yes, describe:

Relationship Type of Problem/Care Needed

_____________________ ____

_____________________ ____

Is there a family history of alcohol or drug abuse/dependency? No Yes If yes, please describe:

____

____

____

NAMASTE
COUNSELING & CONSULTATION
David R. Dagg LPCC-S, LICDC-CS

MEDICAL HISTORY:

Family Physician: Name: ____

Address: ____

Phone Number: ___________________________

Date of your last complete physical exam? ______________________________

Any problems identified? ____

MEDICATIONS CURRENTLY IN USE: (prescribed or over the counter): None used

Medication	Dosage	Schedule	Frequency	Last Used

Psychiatric medications taken in the past: ____

Medication allergies: ____

Other allergies: ____

REVIEW OF SYSTEMS:

VISUAL: No problem State problem ______________________________________

HEARING: No problem State problem ______________________________________

RESPIRATORY: No problem Asthma Hay Fever Congestion Short of breath
Cough up blood Emphysema Wheezing Tuberculosis Sputum production

NAMASTE
COUNSELING & CONSULTATION
David R. Dagg LPCC-S, LICDC-CS

CARDIOVASCULAR: No problem High blood pressure Low blood pressure
Chest pain Palpitations Prior stroke Prior heart attack Fainting episodes

EXCRETORY: No problem Urinary infections Bladder infections
Incontinence of ___ urine ____ stool Excessive night urination

NEUROLOGICAL: No problem Seizures Frequent headaches
Migraines Dizziness Tremors Memory problems
One-sided body weakness Pins and needles sensations
Past history of head injuries

REPRODUCTIVE:
Sexual Orientation: Heterosexual Homosexual Bisexual
Sexually transmitted disease High risk for HIV/AIDS HIV +
Sexual worries Birth control issues Genital herpes

ENDOCRINE: No problem Diabetes Hypoglycemia
Thyroid dysfunction Edema or swelling

GASTROINTESTINAL: No problem Abdominal pain Frequent nausea
Frequent vomiting Weight _____ loss ____gain How much?________
Appetite ____ poor ____ravenous Frequent constipation Frequent diarrhea
Food intolerance

MUSCULOSKELETAL: No problem Muscle impairment/tenderness
Joint pain Back pain, Region ____________________ Restricted motion

CANCER: No Yes
If yes, Describe: ____
Lumps/cysts: ____

Identifying body marks: ____
Accidents/Surgeries: ____

EDUCATION-OCCUPATION-COMMUNITY BACKGROUND

Highest level of education attainment: Elementary education: grade completed ____
High school diploma GED Technical degree Bachelor's Degree
Master's degree Doctoral degree

Have you been told you have a learning impairment or difficulties? No Yes If yes describe:

NAMASTE
COUNSELING & CONSULTATION
David R. Dagg LPCC-S, LICDC-CS

What community resources do you need or use? (i.e., social groups, social media, clubs, self-help groups, community treatment providers, church, social services)

____

____

What or whom do you rely on in times of stress? ______________________________________

____

Are you currently: Employed full-time Employed part-time Disabled
Unemployed Retired: retirement date: _________________________
Student ___ full-time ____ part-time

Occupation or employment title:____

Where are you employed?____

Veteran of Military Service? No Yes If yes, what branch? ____________________

RELIGIOUS/CULTURAL BACKGROUND:
Protestant Catholic Jewish Atheist Other ___________________

How significant a role does spirituality or your religion play in your life? Very important
Somewhat important Minor importance Not important
Your cultural/ethnic background is: ____

Are there any cultural/spiritual needs which might impact treatment or that you want us to know about you? No Yes If yes describe:

____