Elizabeth Soucar, Ph.D., LLC
Licensed Psychologist

Adult Background Information

NAME_____________________________________ Today's Date: ____________________

Date of Birth _______________ Age _____

ADDRESS____

____

____

Home Phone: (___ _)_________________ **May we leave a message? YES NO**

Cell/Other phone: (_____)_____________ **May we leave a message? YES NO**

Do you wish to receive confidential mail at the address listed above? YES NO

If you wish to be contacted or have correspondence sent to an alternative address/phone number please provide the information below:

Emergency Contact: NAME __________________________Phone ____________________

Please circle: Never married partnered married

separated divorced widowed

How many marriages have you had? _________

List the people currently living in your house:

Name	Age	Relationship to You	Occupation

Who referred you?____

Briefly describe your goals for therapy: ____

____

Mental Health Background

List any psychotropic medications (medications for your nerves) that you are taking.

Medication	Dose/Frequency	When Started	For What Symptom(s)?

List any previous mental health or substance abuse treatment (include any inpatient or hospital treatment for a mental health or substance abuse disorder) that you have had.

Date of Treatment (approximate)	Name of Treatment Provider or Agency	What Was Your Problem at the Time?	Were Your Treatment Goals Met?

Was anything in your previous treatment particularly helpful? Not helpful?_______________

____

At this time do you ever have thoughts of harming yourself? YES ______ NO __________

Have you ever attempted suicide? YES ______ NO __________

At this time do you ever have thoughts of harming others? YES ________ NO __________

Social History

Education (please circle)

Did Not Finish High School High School Some College

College Graduate or Professional School

Occupation____

Current Employer (or School)____

How long have you worked there?____

Describe your religious or spiritual orientation? ________________________________

If you have a religion, how often do you attend religious services? (Circle one)

At least weekly monthly several times a year once a year or less

Which of the following statements best describe you (check all that apply)

_____ I have a lot of friends with whom I can confide in or count on
_____ I have many close family members with whom I can confide in or count on
_____ I have a few close friends with whom I can confide in or count on
_____ I have a few close family members with whom I can confide in or count on
_____ I have a lot of friends, but I can't confide in them or count on them
_____ I have few friends and none whom I can confide in or count on

Would you say that you are lonely?

_____ frequently _____ occasionally _____ sometimes _____ rarely

Does your family have a history of mental illness or substance abuse? If so, please explain the nature of the problem, treatment they received and indicate if any particular medication was helpful.

____

____

____

Legal History

Legal Event		If Yes, please give a brief description
Have you ever been arrested?	**YES** **NO**	____ ____
Have you ever been arrested for a DUI (Drinking under the influence?)	**YES** **NO**	____ ____
Have you ever been in prison?	**YES** **NO**	____ ____
Are you currently involved in any litigation?	**YES** **NO**	____ ____

Medical Information

Name of primary care physician or provider ______________________________

Do I have your permission to send basic information (presenting problem, summary of treatment, relevant health information, etc.) to your primary care provider?

YES ________ NO __________

If yes, you will need to sign a specific "authorization" or "release of information form" in order for me to contact your primary care provider.

How would you describe your physical health?

___ excellent ___ good ___ average ___ poor ___ very poor

List any medical conditions that you have.

Medical condition or symptoms	Treatment (s)

List any prescription medications that you take.

Drug	**Dose/Frequency**	**When Started**	**For What Symptom(s)?**

List any non prescription (over-the-counter) medications that you take?

Drug	Dose/Frequency	When Started	For What Symptom(s)?

Do you have any allergies or sensitivities to drugs, foods, or other substances?

YES ________ NO __________

If yes, please indicate the substances that you are allergic to or have sensitivities to:

____

____

Do you smoke or use other tobacco products? YES ________ NO __________

If yes, please indicate what you smoke (or chew) and how much you smoke or chew in an average day.

____

____

Do you drink alcohol? YES ________ NO __________

If yes, please indicate what you drink and how much you drink in an average day.

____

____

Do you use recreational drugs such as marijuana, cocaine, or other drugs?

YES ________ NO __________

If yes, please indicate what you use how much you use in an **average week**.

____

____

What would you say are your personal strengths?

____

____

What are your hobbies and interests?

____

Is there any other information that would be useful to know about you?

____

____

____

____

____ ____________________
Client Signature Date

____ ____________________
Elizabeth Soucar, Ph.D. Date