Psychotherapy Services of CT, L.L.C.
Vernon, CT 06066
Phone: (860) 647-8995
Fax: (860) 647-6930

Adult Client History

Patient: _____ Date: _____

Please list all of the people living in your household:

Name	Sex	Age	Place of work or school

List any family members not living with you (for example, grown children, former spouse):

_____
_____
_____

What problem(s) are you experiencing at this time? _____
_____
_____
_____

What made you decide to see a therapist now? _____
_____
_____
_____

Describe any known drug allergies, or any past major illnesses, injuries, or surgeries:

_____
_____
_____
_____

Check the appropriate box describing your use of cigarettes, alcohol and marijuana:

	CIGARETTES		ALCOHOL		MARIJUANA
Don't Smoke		Don't Drink		Don't Smoke	
< Than 1 Pack/Day		Drink 1/Month		Smoke 1/Month	
1 Pack/Day		Drink 1/Week		Smoke 1/Week	
>1 Pack/Day		Drink More Than 1/Week		Smoke More Than 1/Week	
Do You Want To Quit?		Do You Want To Quit?		Do You Want To Quit?	

Have you ever been arrested for DWI/DUI? If so, indicate the number of DWI's and dates:

_____

_____

Do you use other drugs (for example, cocaine, speed, etc.)? If so, describe:

_____

_____

Have you ever been on probation? Yes__ No__ If so why? _____

_____

Do you ever hear voices or see things that other people can't see or hear? If so, describe:

_____

_____

Do you ever feel that people are out to hurt you? Yes ___ No ___
Do you feel that people are talking about you behind your back? Yes ___ No ___

Do you have any sleep trouble? If yes, check those areas that are problems:

Falling asleep ___ Restless sleep ___ Waking throughout the night ___ Other (explain):

_____

_____

Have your eating habits or weight changed in recent months? If yes, check those areas that describe the change:

Weight loss ___ Loss appetite ___ Weight gain ___ Increased appetite ___

_____

_____

Have you ever seen a counselor or doctor for emotional, mental health or substance abuse difficulties? If yes, list who and when: _____

_____

Have you ever taken any medication for emotional, mental health or substance abuse difficulties?
If yes, what and when: _____
_____

Have you ever been in a hospital for emotional, mental health or substance abuse difficulties?
If yes, for what and when: _____
_____

Have you ever deliberately hurt yourself, overdosed or attempted suicide? If yes, how many times, when and how: _____
_____

Have you had any feelings of wanting to hurt yourself or anyone else **over the past month**?
If yes, describe: _____
_____

Do you or a family member have firearms in your home? ____ Yes ____ No

Has anyone in your family ever committed suicide? If yes, who, when and how? _____
_____
_____

Do any of your family members have emotional, behavioral, mental health or substance abuse difficulties? If yes, who and when: _____
_____

What are your personal strengths and support systems that have allowed you to cope with other difficult life situations in the past? _____
_____

What makes you feel safe? _____
_____

What gives you pleasure? _____
_____

What other things would be helpful for your therapist to know to work most effectively with you?
_____
_____

What <u>specific</u> changes do you want to make in order to feel that your therapy experience has been successful?
1. _____
2. _____
3. _____
4. _____
5. _____

FOR OFFICE USE ONLY:

Check if the following information from the Client Questionnaire was reviewed:

Elaborate if remarkable (e.g., include information not already presented in the Client History Questionnaire:

Family Hx of psychiatric problems: _____

Prior mental health or substance abuse Tx: _____

Current medications: _____

Review the following as needed:

Elaborate if remarkable (e.g., include information not already presented in the Client History Questionnaire:

Educational Hx: _____

Vocational Hx: _____

Military Hx: _____

Other: _____