Boiler Psychological Services,

Phone: 801-661-1992

Adult Client: History Form

Please print, complete this form, and bring it to Dr. Boiler prior to your first session. Information you provide here is held to the same standards of confidentiality as therapy.

Client's name: _____ Date: _____

Gender M F Date of birth:_____ Age: _____

Address:_____ City: _____State:_____ Zip ____

Phone (home)_____Phone (work) _____ Phone (Cell)_____

Can we leave a message? _____yes_____ no If yes, which number: _____

Email: _____

Emergency Contacts:_____

Preferred Way of Contact:

Note: Email and texts are not secure forms of communication.

Specify mode of contact preferred: _____

Referred by:_____

Referral Source:_____

If you need any more space for any of the questions please use the back of any sheet.

Primary reasons for seeking treatment:

What are your goals for treatment:

FAMILY INFORMATION

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
MOTHER	_____	_____	____	_____	_____	_____
FATHER	_____	_____	____	_____	_____	_____
SPOUSE	_____	_____	_____		_____	_____
CHILDREN						

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Significant others (e.g. brothers, sisters, grandparents, step-relatives, roommates). Please specify relationship).

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No

Marital Status

(Please circle all that apply)

Single

Divorce in process
Length of time: _____

Unmarried, living together
Length of time: _____

Legally married
Length of time:

Separated
Length of time: _____

Divorced Length of time:

Widowed
Length of time: _____

Annulment
Length of time: _____

Total number of marriages: _____

Assessment of current relationship (if applicable) Good Fair Poor

*****Some of the following questions are sensitive in nature. If you prefer not to answer them, you can leave them blank.*

Development:

Are there special, unusual, or traumatic circumstances that affected your development?

_____ Yes _____ No

If yes, please describe:

Other childhood issues:

Academic difficulties? If so, please specify:

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Social Relationships

Do you have friends you trust and consider close? Yes No

Do you have casual friends? Yes No

Who is your biggest emotional support during difficult times? _____

Describe the frequency of social interactions, involvement with friends:_____

Prior Assessments:

Have you had any prior psychological/psychiatric/educational assessments? If so, when, and where there any diagnosis made?

Spiritual/Religious

How important to you are spiritual matters?

_____ Not _____ Little _____ Moderate _____ Much

Are you affiliated with a spiritual or religious group?

_____ Yes _____ No

If yes, describe:

Were you raised within a spiritual or religious group?

_____Yes _____No

If yes, describe:

Would you like your spiritual/religious beliefs incorporated into the counseling?

_____Yes _____ No

If yes, describe: _____

Current LegaL Status

Are you involved in any active cases (traffic, civil, criminal)?

Yes____ No_____

If yes, please describe and indicate the court and hearing/trial dates and charges:

Education

Fill in all that apply:

Years of education: _____ Currently enrolled in school? _____ Yes _____ No

High school grad/GED ___yes _____no

Vocational: _____ Number of Years: _____ Graduated: _____ Yes ____ No Major:_

College: _____ Number of years: _____ Graduated: _____ Yes ____ No Major:_

Graduate School __ Number of years: _____ Graduated: _____ Yes ____ No Major:

Other training: _____

Special circumstances (e.g., learning disabilities, gifted):

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Employment

Currently:___FT _____PT _____Temp __ Laid-off _____Disabled ____Retired
___ Social Security _____Student Other (describe): _____

Military

Military experience? ____Yes ___ No Combat experience?____ Yes _____No
Date enlisted:
Discharge date:

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity How often now? How often in the past?

Medications/Health

Current prescribed medications Dose Date Started Purpose Side Effects

Current over-the-counter meds Dose Date Started Purpose Side Effects

Last physical exam _____ Medical Conditions:_____
Last doctor's visit _____

Please check if there have been any recent changes in the following:
__ Sleep patterns ___ Eating patterns ___ Behavior _____Energy level
____Physical activity level _____General disposition _____Weight
____Nervousness/tension
Describe changes:: _____

Please circle behaviors and symptoms that currently occur for you more often than you would like them

Aggression Dizziness Phobias/fears Drug dependence Eating disorder Recurring thoughts Sexual difficulties Sleeping problems Suicidal thoughts

Elevated mood Sexual addiction Sick Fatigue

Gambling Heart often Speech problems Hallucinations

palpitations Thoughts disorganized Depression

Hopelessness Withdrawing Panic Impulsivity Judgment errors Memory impairment

Irritability Attacks Pulling Hair Agoraphobia Anxiety

Loneliness Mood shifts Tics

Other (specify):

Worrying

Obsessions/Compulsions

Fearfulness

to take place:

I recognize that the above information will be used to inform both my treatment and diagnosis.

Client Signature_____

Today's date_____