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Adult Client Background Form

Your Name:_____ Today's Date:_____

What are your primary concerns/specific questions you would like help with?

_____

_____

_____

How long have had the concerns/questions you listed above? _____

_____

Early Developmental/School History:

As a child, did you ever receive any of the following services (if Yes, please state reason for therapy/service and length of time services were received):

Speech/Language therapy No Yes:_____
Occupational therapy No Yes:_____
Special education services No Yes:_____
IEP/504 Plan No Yes:_____

Educational History:

What is your highest level of educational attainment? _____
If you are still in school, what sorts of grades do you typically earn? _____

Social History:

Marital Status (please circle): Never Married Married Separated Divorced Widowed

Please list all of the people you currently live with (leave blank if not applicable):

Name	Relationship to You	Age	M/F

What are some of your personal hobbies/interests:_____

_____

_____

Are you currently employed (please circle)? No Yes

If employed, what is your job title/occupation? _____

If employed, how many hours per week do you typically work?_____

Medical History:

Please list the names and doses of any prescription medications you currently take:

_____

_____

_____

Please list the names and doses of any non-prescription/over-the-counter medications you currently take: _____

_____

_____

Do you have a history of any of the following? If Yes, please explain:

Allergies	No Yes:	_____
Hearing Problem	No Yes:	_____
Vision Problem	No Yes:	_____
Hospitalization	No Yes:	_____
Serious Accident	No Yes:	_____
Serious Illness	No Yes:	_____
Chronic Illness	No Yes:	_____
Seizure	No Yes:	_____
Tics	No Yes:	_____

Are any of the following current concerns for you? If Yes, please explain:

Eating problems	No Yes:	_____
Sleep problems	No Yes:	_____
Stomachaches	No Yes:	_____
Headaches	No Yes:	_____
Menstrual Cycle	No Yes:	_____

Please circle yes/no for a family history of the following. If yes, list who had these issues:

Learning difficulties	No Yes:	_____
ADHD/ADD	No Yes:	_____
Anxiety problems	No Yes:	_____
Autism	No Yes:	_____
Depression	No Yes:	_____
Bipolar Disorder	No Yes:	_____
Suicide attempt	No Yes:	_____
Drug/alcohol problem	No Yes:	_____
“Nervous Breakdown”	No Yes:	_____
Schizophrenia	No Yes:	_____
Any genetic syndrome	No Yes:	_____

Seizure disorder No Yes:_____
Thyroid problems No Yes:_____
Diabetes No Yes:_____

If there is any other information that you think will be helpful, please explain below:

_____
_____
_____
_____

I certify that, to the best of my knowledge, the information provided above is accurate.

_____ _____
Client Signature Date