HEALTHY MINDS PSYCHOLOGY ASSOCIATES
TUCKER: 3760 LAVISTA ROAD, SUITE 102, TUCKER, GA 30084
DUNWOODY: 1370 CENTER DRIVE, SUITE 205, ATLANTA, GA 30338
PHONE: 770-375-8124 / FAX: 770-559-5543
WWW.HMPSYCHOLOGY.COM

ADULT CLIENT HISTORY FORM

This Form is Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ **Age:** _____

Home street address: _____

City: _____ **State:** _____ **Zip:** _____

Name of Employer: _____

Address of Employer: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions: _____

_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

_____

_____

What are your goals for therapy or psychological evaluation? _____

_____

_____

_____

_____

What have you tried so far to accomplish these goals? _____

_____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL & PSYCHOLOGICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO Do you use any illicit drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

Have you been treated by psychiatrist, evaluated by psychologist, or received counseling? YES NO
(Please list approximate dates and reasons): _____

_____

List previous mental health diagnoses:_____

Height _____ Weight (if applicable) _____ Age_____ Gender _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

FAMILY HISTORY:

How would you describe your relationship with your mother?_____

_____

How would you describe your relationship with your father?_____

_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages?_____

How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships_____

Do you have children?____ If YES, how many and what are their ages:_____

Describe any problems your children are having: _____
_____

List the names and ages of those living in your household:_____
_____

Please briefly describe any history of abuse, neglect and/or trauma: _____
_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: _____
_____

Is spirituality important in your life and if so please explain: _____
_____

EDUCATIONAL HISTORY & CAREER

What is your highest level of education?
❒ High School/GED ❒ College Degree ❒ Graduate Degree ❒Vocational ❒ Less than High School

List your Graduation Year: _____ Major: _____ School: _____GPA:_____

Please check if any of the following pertains to you and your school history.
❒ Difficulties with learning. List most difficult academic area(s): _____
❒ History of retention. If checked, which grade(s): _____
❒ Difficulties with emotions and behavior (e.g., anxiety, depression, suspensions): _____
❒ Difficulty making and keeping friends
❒ Frequent moves, truant, or frequent absences from school
❒ Delays in speech and language: Did you receive speech therapy?_____
❒ Received special education services. ❒ Learning disability ❒ADHD ❒Autism ❒ Speech/Language
❒ Emotional- Behavioral ❒Other: _____ What grade(s)?_____
❒ History of accommodations: List them. _____
❒ Difficulty with attention, focus and concentration: _____

What is your current employment/ Title?_____

How long have you been in current position? _____ Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

List previous career positions that you feel are relevant. _____
Describe any job terminations/poor work evaluations._____
_____

What do you think are your strengths? _____
_____

LEGAL HISTORY

Have you ever been arrested or charged with any criminal or civil charges? YES NO. If yes, please explain.
_____

HISTORY OF SYMPTOMS CHECKLIST (please check all that apply):

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Sad moods →			People in General →			Nausea →		
Panic Attacks			Parents			Racing Thoughts		
Mood Changes			Children/ Parenting			Fainting or Dizziness		
Loss of Pleasure			Marriage/Partnership			Avoidance of situations		
Fears			Friend(s)			Shortness of Breath		
Anger/ Irritability			Co-Worker(s)			Hopelessness		
Frequent Arguments			Job/Employer			Chest Pain		
Excessive Worry			Finances			Pain in joints		
Headaches			Legal Problems			Lack of Motivation		
Loss of Memory			Sex/Pornography			Heart Palpitations		
Social Discomfort			History of Abuse			Muscle Tension		
Trust/ Paranoia			Chronic Illness			Flashbacks		
Withdrawal			Domestic Violence			Low Self-Worth		
Communicating with Others			Thoughts of Hurting Someone Else			Making Careless Mistakes		
Drugs or Alcohol			Obsessive Thoughts			Fidgeting Frequently		
Hallucinations			Thoughts of Suicide			Speak Without Thinking		
Hearing Voices			Sleeping Too Much			Aggression/ Fights		
Vomiting after eating			Sleeping Too Little			Completing Tasks		
Restricted eating			Crying Spells			Paying Attention/Focusing		
Severe Weight Gain			Guilt/ Shame			Fatigue/ Tired		
Severe Weight Loss			Nightmares			Hyperactivity		
Change in appetite			Head Injury			Gambling or Addiction		

FAMILY HISTORY OF (Check all that apply):

Drug/alcohol problems		Depression		Physical or emotional abuse			
Schizophrenia		Anxiety/ Panic attacks		Sexual abuse			
Domestic violence		ADHD		Psychiatric hospitalization			
Bipolar Disorder		Learning disabilities		Suicide attempts/completions			

Include any additional information you would like to provide:

_____

_____