Bright Horizons Counseling Services, LLC
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Adult Information Form

Client Name:			Date:	
Birthplace:	Age:	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed		
Home Street Address:	Apt.:	City:	State:	Zip:

Reason for seeking treatment at this time:

Current Symptoms include (check all that apply):

☐ I have no problems or concern bringing me here	☐ Eating problems	☐ Obsessions/ compulsions	☐ Spiritual, religious, moral, ethical issues
☐ Aggression, violence	☐ low energy	☐ Pain, chronic	☐ Stress
☐ Anger problems	☐ Fears, phobias	☐ Panic or anxiety attacks	☐ Suicidal thoughts
☐ Attention problems	☐ Financial problems	☐ Perfectionism	☐ Temper problems
☐ Career concerns, goals, and choices	☐ Grief	☐ Relationship problems	☐ Thought disorganization and confusion
☐ Parenting issues (your own child)	☐ Health, medical concerns	☐ School problems	☐ Withdrawal, isolating
☐ Custody of Children	☐ interpersonal conflicts	☐ Self-esteem	☐ Work problems
☐ Delusions (false ideas)/ Hallucinations	☐ legal matters problems	☐ Sexual problems	☐ Other concerns or issues:
☐ Dependence	☐ loneliness	☐ Shyness, oversensitivity to criticism	_____
☐ Depression	☐ marital/relationship problems	☐ Sleep problems	_____
☐ Divorce, separation	☐ Memory problems	Smoking and tobacco use	_____
☐ Drug use	☐ Mood swings		_____
	☐ Nervousness, tension		

How long have these difficulties been present?

What are your goals for treatment?

Mental Health History:

Previous Mental Health Treatment:			
Date(s)	Therapist/Facility	Reason for seeking treatment	Was treatment helpful?

Have you been prescribed any psychiatric medications in the past?			
Date(s)	Medication	Reason for prescription	Reason Stopped

Psychiatrist name (if applicable):	
Psychiatrist Address	
Psychiatrist phone#	
Psychiatrist fax #	
Diagnosis:	

	Yes	NO	If yes, please describe:
Have you ever been hospitalized for mental health reasons:			
History of suicidal thoughts or threats:			
Suicidal gestures and/or attempts:			
Any legal history:			
History of involvement in lawsuits:			
History of substance abuse and/or treatment for alcohol and/or drug use:			

Medical History

Please list all medical problems:		
Physician:		Current Medications:
Physician Address:		
Physician Phone #:		
Physician Fax #:		

Are you currently prescribed			
Date(s)	Medication	Reason for prescription	Was medication helpful?

Family History

Children (if any)?	Age	Sex	Living at Home? Yes	No
Is there anyone else living at home?				

Siblings

Name	Age	Relationship
What was your birth order: _____ out of _____		

Education		Spouses' Education (if applicable)	
Highest Degree Completed:		Highest Degree Completed:	
Major		Major	
History of Learning Disorder/Difficulties, If yes, please describe:			

Employment/Educational History

Employment		Spouses' Employment (if applicable)	
Occupation:		Occupation:	
Place of Employment:		Place of Employment:	
Years Employed:		Years Employed:	
Current work difficulties:			

Family Background information:

	Yes	NO	If yes, please describe:
History of psychiatric/psychological disorders in family:			
History of substance abuse in family:			
Is there a history of suicide in the family:			
Early childhood experiences (Briefly describe family, problems in childhood, relationship with family, etc.)			

Other:

Is there anything else I should know that doesn't appear on this form or other forms, but that is or might be important?

My signature below indicates that I have voluntarily and accurately completed the Form. A photocopy of this agreement will be considered as valid as an original.

Client name	Signature of Client	Date

Witness name	Signature of Witness	Date