Adult Background Information

SMU Center for Family Counseling
5228 Tennyson Parkway*Plano, TX 75024
972-473-3456 (phone)* 972-473-3490 (fax)
www.smu.edu/familycounseling

Welcome to the Center for Family Counseling at SMU! Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your intake counselor will discuss your responses with you after he/she has reviewed the form.

Name: _____ *First Visit Date:* _____
Last First MI
Gender Identification: Male__ Female__ Other: _____
*Date of Birth*_____ *Age*_____

Occupation: _____ *Length of Time at this Job:*_____

Ethnicity:
African American___ Bi-racial___ Hispanic/Latino___
Asian___ Caucasian___ Native American___ Other _____

Primary language: English ___ Spanish ___ Other ___

CONTACT INFORMATION:

Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Best Time and Place to call:_____
Mailing Address:_____
Street City State Zip
May we correspond with you via mail at the above address: Yes No

In case of emergency, I authorize the Center for Family Counseling to contact:
_____
Name: Last, First Relationship

Person responsible for financial arrangements with our clinic: _____
Name: Last, First
Who referred you to our Center? (Please be specific): _____

May we contact this referral source to thank them for the referral: Yes No

SMU. ANNETTE CALDWELL SIMMONS SCHOOL OF EDUCATION & HUMAN DEVELOPMENT

CURRENT CONCERNS

General reason(s) for seeking counseling services at this time: _____

_____

_____

*Circle all items that you see as ongoing struggles in your life that you would like to work on in counseling

Issues Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment/rejection
Suspected sexual abuse
History of family domestic violence

Mood-Related Concerns
Disturbing memories
Difficulty going to sleep/Staying asleep
Nightmares/Night terrors
Suicidal thinking or talking
Suicidal attempting
Sadness/Depression
Feelings of guilt and shame
Excessive worrying or fear

Behavioral/Conduct Issues
Aggression toward others
Drug/alcohol use
Hyperactive/Impulsivity
Excessive computer use
Lying
Betraying relationships
Engaging in high risk-taking behaviors
Fire-setting

Career/Academic Issues
Colleague/Cohort problems
Harassment issues
General work performance issues
Failing grades
Chronic stress
Career dissatisfaction
General problems at work/school

Family Relationship Concerns
Difficulty adjusting to family changes
Parenting/Discipline concerns
Parent-child relationship problems
Divorce
Separation
Religious/Spiritual Concerns
Estranged relationships
Constant fighting

Other Behavioral Concerns
Sexual identity questioning
Sexual issues in general
Appetite/Eating concerns
Sleep problems
Time management concerns
Inattentive
Lonely
Bored with Life

Other unusual behaviors (please specify) _____

Please place a star by the most significant issue

*Please briefly discuss the above behaviors you have concerns about:*_____

_____

_____

When did you first become concerned about the main/most significant issue?_____

Why, at this point, have you decided to pursue counseling for the concern(s) above? _____

_____

_____

Other treatment you have received to address any of the concerns indicated above: None____

Couples Counseling___ Group counseling___ Individual counseling___
Family counseling___ Hospitalization___ Other _____

Are you currently in counseling elsewhere? Yes No
(If yes, we require written confirmation of the counselor's consent for treatment by the center)

Are other family members receiving services at this clinic? Yes No
(Name/Dates of service)_____

Are you seeking services because you are a victim of a crime? Yes No

If yes, did it result in legal action? Yes No *Are you currently on probation?* Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If yes, we will need your permission in order to communicate with that individual or agency. We reserve the right to postpone services until prior treatment providers are contacted.)

Previous Mental Health Professional/Agency_____
Name Address
Phone_____ Dates of Service_____(beginning - ending)

Have you ever been hospitalized for mental health concerns: Yes No

If yes please explain: _____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____
Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly
1_____2_____3_____4_____5

Are you currently involved in a custody dispute: Yes No (If yes, explain) _____
_____

Current living arrangements:

Family of origin___ Relatives___ Single ___
Married___ Partner__ Roommate(s)___
Single parent w/children__ Partner w/ children__ Married w/children___
Significant other___ Significant other w/ children___ Other_____

Present Family

If married with children, list your family, beginning with the oldest member and include yourself.

Name	Age	Gender	Relationship to you (include step, half, etc.)

Family of Origin Primary Household (Family in which you resided the majority of your life)

List your family members, by household, beginning with the oldest member (include parents and self):

Name	Age	Gender	Relationship to you (include step, half, etc.)

Family of Origin Second Household (if applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)

Mother's Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married___
Married_____ Remarried_____ Divorced_____
Separated_____ Widowed_____ Unknown_____
Number of marriages_____

Father's Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married____
Married_____ Remarried_____ Divorced_____
Separated_____ Widowed_____ Unknown_____
Number of Marriages_____

HEALTH

*Primary Care Physician:*_____
Name

_____
Address Phone

Psychiatrist: _____
Name

_____
Address Phone

Date of LAST complete physical: _____
Physical disability: Yes No (if yes, explain) _____
Chronic illness: Yes No (if yes, explain) _____
Terminal illness: Yes No (if yes, explain) _____

Check the following items for a diagnosis or medication you are now receiving or have received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Learning disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____

Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If you have been diagnosed, who gave the diagnosis?
Counselor/Psychologist___ Family Physician___ Psychiatrist___ School___ Other_____
Name: _____ Phone #: _____

List other medication you are currently taking:
Med._____ Dosage_____
Med._____ Dosage_____
Med._____ Dosage_____

Health/Physical Problems (check all that apply):

Asthma___	Disability___	Nervous stomach ___	
Bedwetting___	Dizziness ___	Neurological problems/Exam___	
Bone/Joint/Muscle ___	Headache (kind) ___	PMS ___	
Chest pain ___	Heart palpitations___	Serious overeating/Under eating__	
Chronic illness___	Hospitalization___	Shortness of breath without exertion ___	
Developmental delay(s)___	Major accident___	Sleep problem___	
Diarrhea ___	Major illness___	Surgeries___	Other _____

FAMILY HISTORY/EXPERIENCES

(**For each of the following items that apply, write in your <u>approximate age</u> at the time it occurred):**
Raised by:

Adoptive parent(s)___	Institution___	Relatives___
Foster parents___	Natural parents___	Single natural parent___
Grandparents___	Natural and step-parent___	Other_____

Stressors in the Family:
Chronic illness of family member___ Death of significant person___ Domestic Violence____
Family member absent (explain) _____
Family member disability/Major accident/illness___
Family member emotional problems (explain) _____
Family member suicide (explain) _____
Financial problems___ Moved a lot___ Parents arguing frequently___ Parents divorced___
Other _____

History of learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

History of Protective orders: Yes No
*(If yes, please explain)*_____

Abused (check all that apply): Physically___ Emotionally___ Sexually___
Neglected (check all that apply): Physically___ Emotionally___

Dissociative Symptoms (check all that apply):

Amnesia of large parts of childhood after age 5___
Memories suddenly flashback___
Things appear but you don't know origin___
Things of yours that are missing___
Trance-like episodes/Lost track of time___
Walk in sleep___

Trauma/Stressor (check all that apply):

Child separated from parent (how long and when) _____
Death of a pet___
Death of a significant person___
Incarcerated family member___
Medical___
Natural disaster___
Sexual assault___
Victim of trauma (unusual, terrifying experience)___
Other _____

Interpersonal Problems (check all that apply):

Aggressive behavior (explain) _____
Bullied___
Taken advantage of___
Frequent arguments___
Temper outbursts__
Loner___
Other_____

Specific to Adulthood (check all that apply):

Abortion___
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment, etc.)___
Parenting/Discipline problems ___
Placing child for adoption___
Sexual problem (explain) _____

Family of Origin Atmosphere (circle the number that best describes how you viewed your family while you were growing up):

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family of Origin Support System (such as church, friends, relatives, school)

Hardly any support	1	2	3	4	5	Considerable support

Family Atmosphere (circle the number that best describes how you view your current family, if applicable):

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)

Hardly any support	1	2	3	4	5	Considerable support

Your current use of computer and television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

What do you enjoy doing the most on the computer: _____

TV (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

What do you watch on TV:_____

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my screening/intake counselor at any time. I also understand that completing this intake does not guarantee that counseling services will be rendered at this Center.

_____

Client/Guardian Date

2/16/2010