Amber M. Prather, MA, LPC
405-206-4214
Fax 216-236-7231

Adult Client Information Form

Date: ________________________ Insurance: ____

A. Identification

Your name: ____________________________________ Date of birth: ____________ Age: _________

Marital Status: __________________________ Social Security #: ___________________________

Home street address: ____ Apt.: ________________

City: ____ State: __________ Zip: _______________

Home/evening phone: ___________________ Cell Phone: ______________________________

Email address (you will NOT be put on any lists) ____

B. Referral: How did you find me? ____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: ______________________________________ Phone: _________________________

Address: ____

Current medications/dosages: ____

____

D. Current job or daily routine: ____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

E. Your education and training

	Name of school/college	Dates:
High School	______________________________________	_____________________
College/s	______________________________________	_____________________
	______________________________________	_____________________

F. Employment experiences (include military if applicable)

Dates From	To	Name of employers	Job title or duties	Reason for leaving
______	_______	_____________________	_____________________	_________________________
______	_______	_____________________	_____________________	_________________________
______	_______	_____________________	_____________________	_________________________
______	_______	_____________________	_____________________	_________________________

G. Have you participated in counseling or therapy before? _________Yes___________No

Name of counselor/therapist:____

How long did you go to counseling?____

H. Family-of-origin history:

Family Member	Living? (Y/N)	Age	Health Good	Fair	Poor	If deceased, when?
Father						
Mother						
Brothers						
Sisters						

- Are your parents still married to one another? ____yes____no
- If parents divorced, how old were you when they divorced?_________________
- With whom did you grow up? (what parents & siblings)?________________________________
  ____

Check condition and relationship of any relative who has or has had any of the conditions listed below. Include yourself	YOURSELF	Mother	Father	Siblings	Stepmother	Stepfather	Paternal grandfather	Paternal grandmother	Maternal grandfather	Maternal grandmother
Alcoholism/Substance Abuse										
Cancer										
Depression										
Anxiety/Panic										
Heart problems										
High Blood Pressure										
Migraines										
Serious Mental Illness (bipolar,schizophrenia, etc.)										
Learning/Attention Problems										
Suicide/Suicide Attempt										
Gastro-intestinal problems										
Other (Specify)										

I. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First	________________	_________	__________	____________________	____________
Second	________________	_________	__________	____________________	____________
Third	________________	_________	__________	____________________	____________

Date of current marriage: __________ Spouse's name: ____________________ Spouse's age: _____

- Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? __________
- On a scale of 1-10, how would you rate your relationship? __________

J. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

K. Spiritual Life

- Would you like to incorporate spiritual or religious beliefs in your counseling?____Yes____No
  If yes, describe your faith or belief:

  ____

L. GENERAL HEALTH AND MENTAL HEALTH INFORMATION

- How would you rate your current physical health? (please circle)

  Poor Unsatisfactory Satisfactory Good Very good

- Please list any specific health problems you are currently experiencing:

  ____

- How would you rate your current sleeping habits? (please circle)

  Poor Unsatisfactory Satisfactory Good Very good

- Please list any specific sleep problems you are currently experiencing:

  ____

- How many times per week do you generally exercise? __________

  What types of exercise to you participate in ____________________________________

- Please list any difficulties you experience with your appetite or eating patterns

  ____

- Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
  If yes, for approximately how long? ________________________

- Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
  If yes, when did you begin experiencing this? ___________________________

- Are you currently experiencing any chronic pain? □ No □ Yes
  If yes, please describe ____

- Do you drink alcohol more than once a week? □ No □ Yes

- How often do you engage recreational drug use?
  □ Daily □ Weekly □ Monthly □ Infrequently □ Never

- What significant life changes or stressful events have you experienced recently:

  ____

  ____

What do you consider to be some of your strengths?

____
____
____
____

What do you consider to be some of your weakness?

____
____
____
____

What would you like to accomplish out of your time in therapy?

____
____
____
____

Please note: information you provide here is protected as confidential information.