# Hollie Wilson Counseling

**2000 Highland Village Road, Suite C**
**Highland Village, TX 75077**
**Phone: (205) 238-1207**
**www.holliewilsoncounseling.com**


## ADULT INFORMATION FORM

| | | |
|---|---|---|
| Name | Date of First Appointment | Therapist: Hollie Wilson, LCSW-S |
| Date of Birth | Age | Gender ❑Male ❑Female |

| | |
|---|---|
| Name of Primary Care Physician | Physician's Phone |
| Physician's Address | |

Many managed care companies require that we interact with the client's physician to coordinate care. Do you give us consent to discuss your care with the above-named doctor? ❑YES ❑NO

Please sign here for either answer

| | |
|---|---|
| Date of last medical evaluation | Date of next appointment |

| Name of medication | Dosage/Frequency | Start Date | Purpose | Prescribed By |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Have you ever been hospitalized for medical or psychiatric reasons? ❑YES ❑NO

| Hospital | Month/Year | Reason |
|---|---|---|
| 1. | | |
| 2. | | |

| Do you use recreational drugs? ❑YES ❑NO | If no, have you used previously? ❑YES ❑NO | If yes, when did you stop? |
|---|---|---|
| Type of Drug | How Much | How Often |
| 1. | | |
| 2. | | |

| | | |
|---|---|---|
| 3. | | |
| | | |
| Do you drink alcohol? ❑YES ❑NO | If no, did you drink previously? ❑YES ❑NO | If yes, when did you stop? |
| Type of Alcohol | How Much | How Often |
| 1. | | |
| 2. | | |
| Do you smoke cigarettes? ❑YES ❑NO | Do you smoke electronic cigarettes? ❑YES ❑NO | Do you use other forms of tobacco? ❑YES _____ ❑NO |

| |
|---|
| Describe any important medical history, chronic ailments, or other health problems you experience: |
| Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: |
| Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: |

| |
|---|
| Did you experience any developmental, academic, or behavior problems as a child or while in school, with peers or teachers? ❑YES ❑NO |
| If yes, please explain: |
| What was the last year of school you completed? |

If you did not complete high school, please explain:

Please list schools currently attending, last attended, and graduated:

| | |
|---|---|
| Currently attending: | Year(s) |
| Last attended: | Year(s) |
| Graduated: | Year(s) |

How would you describe your current support network? (friends, relatives, etc.):

Please check all information which applies to your biological parents:

| MOTHER | FATHER |
|---|---|
| ❑ living | ❑ living |
| ❑ deceased | ❑ deceased |
| ❑ married | ❑ married |
| ❑ divorced | ❑ divorced |
| ❑ remarried ___ # of times | ❑ remarried ___ # of times |

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? ❑YES ❑NO If so, whom?

_____

Where do your parents live?

Mother:

Father:

Describe your relationship with your mother while growing up:

Describe your relationship with your mother currently:

Describe your relationship with your father growing up:

Describe your relationship with your father currently:

List first names and ages of brothers and sisters, including yourself:

| Name | Age | Relationship (natural, step, half, etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Describe any family problems which occurred while growing up relating to:

Alcohol / drug abuse:

Sexual / physical / emotional abuse:

Relationship status: ❑ Single / never married ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Partnered

| If currently married, when were you married? | If living with someone, how long? |
|---|---|

Please list your children:

| Name | Age | Relationship (biological/step) | Lives With |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**MENTAL STATUS**

Please check any of the following that describe how you have been feeling lately:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ❑ sad | ❑ anxious | ❑ depressed | ❑ frightened | ❑ guilty | ❑ angry | ❑ ashamed | ❑ aggressive | ❑ resentful |
| ❑ worthless | ❑ tearful | ❑ irritable | ❑ confused | ❑ extreme ups/downs | ❑ jealous | ❑ hopeless | ❑ helpless | ❑ other |

Describe any other feelings you have had:

What activities or hobbies do you participate in?

Do you participate in regular exercise? ❑YES ❑NO
Describe:

Describe your current working environment:

Have you had any change in sleeping habits? ❑YES ❑NO
Describe:

Have you had any change in eating habits? ❑YES ❑NO
Describe:

Have you ever **considered suicide** in connection to your **current** problem? ❑YES ❑NO
If so, please give a brief description with dates:

Have you ever **considered suicide** in the **past**? ❑YES ❑NO
If so, please give a brief description with dates:

Have you **attempted suicide recently** or in the **past**? ❑YES ❑NO
If so, please give a brief description with dates:

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? ❑YES ❑NO
If yes, please explain:

Have you ever **considered homicide** in the **past**? ❑YES ❑NO
If yes, please explain:

## LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social, or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, problems with supervisor, etc.):

**THOUGHTS:** Please check any of the following that apply to you:

❑ I sometimes hear voices even though no one nearby is talking to me.
❑ I sometimes feel that forces outside of me control me.
❑ I sometimes feel that other people control my thoughts.
❑ I sometimes have the same thought over and over and cannot control it.
❑ I sometimes feel that someone is out to hurt me or do something against me.
❑ I am sometimes unable to control my behavior.

Please explain:

**OTHER INFORMATION**

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

## THANK YOU!