The Human Aspect LLC

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ADULT CLIENT SELF-REPORT

Date ___/_____/____ Date of Birth____/____/____ Age _____ Gender _____

Name _____
First Middle Last

Address _____
Street Apt. # City State Zip Code

Phone _____
Home Business Mobile

Employer/School _____

Occupation/Grade _____

Education (Highest grade or degree completed) _____

Religion/Denomination _____

Who referred you here? _____

Military service? Yes ____ No ____ Dates _____

Did you serve in combat? Yes ____ No ____

FAMILY INFORMATION

Mother _____
Name Age Deceased? Date Age at Time

Father _____
Name Age Deceased? Date Age at Time

Brother/Sister _____
Name Age Deceased? Date Age at Time

Brother/Sister _____
Name Age Deceased? Date Age at Time

Brother/Sister _____
Name Age Deceased? Date Age at Time

Brother/Sister _____
Name Age Deceased? Date Age at Time

Brother/Sister _____
Name Age Deceased? Date Age at Time

Name _____

Married or in significant relationship? Yes ____ No ____ If yes, how long? _____

Spouses or partner's name _____

Previous marriages or significant relationships

Name _____ Date from _____ to _____

Name _____ Date from _____ to _____

Name _____ Date from _____ to _____

Name _____ Date from _____ to _____

CHILDREN

Name	Age	Gender	Married?	Children?
Name	Age	Gender	Married?	Children?
Name	Age	Gender	Married?	Children?
Name	Age	Gender	Married?	Children?
Name	Age	Gender	Married?	Children?

Have any children died? Yes ____ No ____

If yes, please give details _____

BACKGROUND

Did your parents ever have problems with alcohol or drug use?

Never ____ Seldom _____ Sometimes ____ Often ____ Very Often ____

Did you ever have problems with alcohol or drug use?

Never ____ Seldom _____ Sometimes ____ Often ____ Very Often ____

Name _____

Did you ever observe abuse (verbal, emotional, or physical) between your parents?

Never ____ Seldom _____ Sometimes ____ Often ____ Very Often ____

Were you ever abused (verbally, emotionally, physically, or sexually) by parents?

Never ____ Seldom _____ Sometimes ____ Often ____ Very Often ____

Have you ever been abused (verbally, emotionally, physically, or sexually) by your partner?

Never ____ Seldom _____ Sometimes ____ Often ____ Very Often ____

Have you ever been abused (verbally, emotionally, physically, or sexually) by anyone else?

Never ____ Seldom _____ Sometimes ____ Often ____ Very Often ____

PREVIOUS THERAPY EXPERIENCE

Date Provider Duration Inpatient or outpatient? Mental Health or Substance?

_____

_____

_____

_____

_____

Are you currently in treatment with another therapist? Yes ____ No ____

If so, whom are you seeing? _____

MEDICAL INFORMATION

Primary care physician _____

Are you currently on psychiatric medications? Yes ____ No ____

Medication Condition Prescriber

_____

_____

_____

_____

Name _____

Past surgeries or serious medical conditions

_____

_____

_____

_____

Allergies or adverse reactions to medications Yes ____ No ____

If yes, please describe _____

_____

_____

CURRENT CONCERNS

What do you consider your most significant difficulty or problem?

_____

_____

_____

_____

_____

_____

_____