Client Name _____

Family Resource NETWORK and Kaleidoscope Counseling

Adult History/Information

Welcome! I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help me better understand your situation as well as potential solutions in helping you get your life back on track. Please note - the information is confidential and will not be released to anyone without your written permission.

D.O.B. _____

Sources of Stress

Please list the reasons that bring you here today. This may include certain problems, issues, relationships, significant losses, or changes that are causing you problems.

1. _____

2. _____

3. _____

4. _____

Adult Strength Scale

Please circle the areas below that apply to you

Home

1. I feel part of the family	Never	Sometimes	Often	Always	N/A
2. I am physically healthy	Never	Sometimes	Often	Always	N/A
3. I have an enjoyable social life	Never	Sometimes	Often	Always	N/A
4. I feel accepted by others	Never	Sometimes	Often	Always	N/A
5. I am a good father/mother	Never	Sometimes	Often	Always	N/A
6. I participate in decision making	Never	Sometimes	Often	Always	N/A
7. There has been violence in the home	Never	Sometimes	Often	Always	N/A

Comments: _____

_____

Marriage/Significant Other (Circle **N/A** if this does not apply)

1. I have considered divorce/separation	Never	Sometimes	Often	Always	N/A
2. I get along with my partner	Never	Sometimes	Often	Always	N/A
3. My partner has been violent	Never	Sometimes	Often	Always	N/A
4. My partner and I can solve conflicts	Never	Sometimes	Often	Always	N/A
5. I feel understood by my partner	Never	Sometimes	Often	Always	N/A
6. Our sexual relationship is satisfying	Never	Sometimes	Often	Always	N/A
7. Affairs are a concern in our relationship	Never	Sometimes	Often	Always	N/A

Comments: _____

_____

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Work (Circle **N/A** if this does not apply)

1. I get to work on time	Never	Sometimes	Often	Always	N/A
2. I get along with my co-workers	Never	Sometimes	Often	Always	N/A
3. I am respected by my co-workers	Never	Sometimes	Often	Always	N/A
4. I am respected by my supervisor(s)	Never	Sometimes	Often	Always	N/A
5. I enjoy working	Never	Sometimes	Often	Always	N/A
6. I have realistic career goals	Never	Sometimes	Often	Always	N/A
7. I am a hard worker	Never	Sometimes	Often	Always	N/A
8. I balance home and work	Never	Sometimes	Often	Always	N/A

What are your current job duties; for how long?_____

Comments: _____

_____

Emotional

1. I cope well with frustration	Never	Sometimes	Often	Always	N/A
2. I cope well with disappointment	Never	Sometimes	Often	Always	N/A
3. I use anger constructively	Never	Sometimes	Often	Always	N/A
4. I am satisfied with life	Never	Sometimes	Often	Always	N/A
5. I accept responsibilities for my mistakes	Never	Sometimes	Often	Always	N/A
6. I drink (alcohol) responsibly	Never	Sometimes	Often	Always	N/A
7. I can take constructive criticism	Never	Sometimes	Often	Always	N/A
8. I think before I act	Never	Sometimes	Often	Always	N/A
9. I have good self-esteem	Never	Sometimes	Often	Always	N/A
10. I have used drugs to help me cope	Never	Sometimes	Often	Always	N/A
11. I have considered suicide	Never	Sometimes	Often	Always	N/A

Comments: _____

_____

_____

Social

1. I make and keep friends	Never	Sometimes	Often	Always	N/A
2. I'm open to new ideas	Never	Sometimes	Often	Always	N/A
3. I am considerate of others	Never	Sometimes	Often	Always	N/A
4. I stand up for myself	Never	Sometimes	Often	Always	N/A
5. I show leadership	Never	Sometimes	Often	Always	N/A
6. I am able to compromise	Never	Sometimes	Often	Always	N/A
7. I'm comfortable around others	Never	Sometimes	Often	Always	N/A
8. I get along with others	Never	Sometimes	Often	Always	N/A
9. People can trust me	Never	Sometimes	Often	Always	N/A
10. I am in trouble with the law	Never	Sometimes	Often	Always	N/A

10.What do you do for recreation/leisure? _____

Comments:_____

_____

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Attention

1. I cope with external distraction	Never	Sometimes	Often	Always	N/A
2. I maintain attention to tasks	Never	Sometimes	Often	Always	N/A
3. I follow through on tasks	Never	Sometimes	Often	Always	N/A
4. I am able to concentrate	Never	Sometimes	Often	Always	N/A

Comments: _____

_____

Spiritual/Faith

1. I attend church regularly	Never	Sometimes	Often	Always	N/A
2. Prayer is important to me	Never	Sometimes	Often	Always	N/A
3. I am confident in my spiritual beliefs	Never	Sometimes	Often	Always	N/A
4. My spiritual life is helpful to me	Never	Sometimes	Often	Always	N/A

5. Religious Affiliation in Childhood_____ Currently_____

Problems That You Are Struggling With

Please check (X) those that apply to you:

( ) Depression	( ) Parent-child conflict (self)	( ) Anxiety or panic attacks
( ) Parent-child conflict (spouse)	( ) Suicidal thoughts or actions	( ) Marital/relationship problems
( ) Blended family problems	( ) Divorce issues	( ) Pornography
( ) Anger/temper problems	( ) Violence in family - actual or threatened	
( ) Job/school issues	( ) Sexual problem	( ) Sexual Abuse - past/present
( ) Employment issues	( ) Low self - esteem	( ) Legal - specify
( ) Eating problems	( ) Compulsive gambling	( ) Loss/Difficult transition
( ) Death of a loved one	( ) Communication problems	( ) Financial problems
( ) Spiritual problem	( ) Cultural issues	( ) Disability - specify
( ) Life transition problem	( ) Medical Problems	( ) Gambling

( ) Alcohol/Drugs: If yes please indicate details:

Substance	Date last used	Amount	Frequency	# of years used

Current Symptoms

Please check (X) those that apply to you

( ) Sleep problems
- ( ) Difficulty falling asleep
- ( ) Waking in the middle of the night
- ( ) Waking too early
- ( ) Sleeping to much
- ( ) Nightmares

( ) Moody or crying more than usual

( ) Difficulties concentrating

( ) Problems remembering things

( ) Withdrawing from others

( ) Change in appetite
- ( ) Gaining weight (specify _____)
- ( ) Losing weight (specify _____)
- ( ) Not hungry or not eating
- ( ) Throwing up after eating
- ( ) Feeling sick to my stomach

( ) Constipation or diarrhea

( ) Feeling guilty, worthless, or hopeless

( ) Fatigue/low energy

( ) Hyper/too much energy

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( ) Repeated actions I can't stop
( ) Can't stop washing hands/body, counting or checking things
( ) People picking on me
( ) Self-harm
( ) I cut myself
( ) I burn myself
( ) Other _____

( ) Loss of interest in things
( ) Disturbing thoughts I can't stop
( ) Low self esteem
( ) Hallucinations
( ) I hear things that are not real
( ) I see things that are not real
( ) I smell things that are not real
( ) I feel things that are not real

List Any Previous Suicide Attempts (if none, write "None")

When Method

_____

_____

List Previous Inpatient Psychiatric and/or Drug-alcohol Rehab. Hospitalizations (if none, write "None")

Dates (from-to) Reason

_____

_____

Previous or Current Counseling (if none, write "None")

Therapist or Agency From/to Focus of Sessions

_____

_____

What was helpful and/or not helpful about your previous/current counseling experience? _____

_____

What are your medical problems (current or past)? _____

_____

Current medication (s) you regularly take –
please include prescription, over the counter, and any herbal remedies (if none, write "None")

Name of Medication Dosage How often/day

_____

_____

_____

_____

Are You Allergic to Any Drugs (Please List)? _____

Are you currently on probation? Have you ever been in jail or prison? (if yes, please explain)

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Family Information

Please list the people that you currently live with

Name	Relationship	Age

Do you have other children not living with you? If yes, please give names and ages_____

_____

Does your family have any psychiatric or substance abuse history? (please list)

_____

_____

What is your relationship like with your parents (past and current)? _____

_____

_____

How would you describe your cultural background?

_____

_____

Please list family, friends, support groups and community groups that are helpful to you

_____

_____

_____

Have you ever been in the military? If yes, please provide details _____

_____

Are you a student? YES / NO What is your highest level of your schooling? _____

Are there any guns or weapons in your house? (please list and state for purpose you use them)

_____

_____

Current Functioning

Please place an "X" on the following scale to indicate how well you are coping <u>at the present time.</u> 100% means that you are coping the best that you can considering your situation.

( ) 10% ( ) 20% ( ) 30% ( ) 40% ( ) 50% ( ) 60% ( ) 70% ( ) 80% ( ) 90% ( ) 100%

Thank you for taking the time to complete this information.