Clymene Baugher, M.A., LMHC
17 W. 74th St.
No.4A
New York, NY 10023
Phone: 352-250-7797 www.clymeneco.com

ADULT INFORMATION FORM

Name____ Date of 1st Appointment______________ DOB:_________________ Age:_______

Gender: Female ____Male ____Transgender____ Race/Ethnicity/Cultural Background:____________________________________

Sexual Oriention:_________________________ Religious Preference:_________________ Personal Identity:______________________

MEDICAL HISTORY

Name of Primary Care Physician: ____

Physician's Address:____Physician's Phone: _____________________________

Many managed care companies require that counselors have interaction with the client's physician to coordinate care. Do you give Clymene Baugher, LMHC consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:____

Date of last medical evaluation:______________________ Date of next appointment:________________________________

Current medications being taken:

1)________________________ Dosage/Freq____________ Start Date____________Purpose________________________________

2)________________________ Dosage/Freq ____________ Start Date____________Purpose________________________________

3)________________________ Dosage/Freq ____________ Start Date____________Purpose________________________________

4)________________________ Dosage/Freq ____________ Start Date____________Purpose________________________________

Prescribed by: ____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
____________________________________	__________	____
____________________________________	__________	____
___________________________________	__________	____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? ________________________________

Type of Drug	How much	How often
_______________________________________	______________	____
_______________________________________	______________	____
_______________________________________	______________	____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_______________________________________	______________	____
______________________________________	______________	____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? ____

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: ____

____

____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) 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 (1) currently attending, (2) last attended, (3) graduated:

(1) School(s)______________________________ Year(s)______________________________

(2) School(s)______________________________ Year(s)______________________________

(3) School(s)______________________________ 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? If so, whom?

____

Where do your parents live? Mother ____

Father ____

Describe your relationship with your mother while growing up:____

____

Currently: ____

____

Describe your relationship with your father while growing up: ____

____

Currently: ____

____

List first names and ages of brothers & 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: ____

____

____

PARTNER/MARITAL HISTORY

Partner status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? __________________ If living w/someone, how long? __________________

List any children: Name Age Relationship (biological/step) Lives with

Name	Age	Relationship (biological/step)	Lives with
______________	______	______________	______________
______________	______	______________	______________
______________	______	______________	______________

Describe any significant past and/or present relationships: ____

____

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

Describe any other feelings you have had: ____

____

What activities or hobbies do you participate in? ____

____

Do you participate in regular exercise? (Circle One) YES NO Describe: ____

Describe your current working environment: ____

____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: ____

____Past sleeping concerns: ____

Have you had any change in eating habits? (Circle One) YES NO Describe: ____

____Past eating concerns: ____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: ____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: ____

Have you **attempted suicide recently** or in the **past**? (Circle One) 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? (Circle One) YES NO

If yes, please explain: ____

Have you ever **considered homicide** in the **past**? (Circle One) 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, and 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:______________________

____

____

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.

____

____

What brings you to therapy today? Presenting Concerns:

____

____

____

____

Please list your therapy goals:

____

____

____

____

CONTACT INFORMATION:

Address:____

______________________ Is it OK to mail you things at this address? (Circle One) YES NO

Home Phone:______________________ Cell Phone:______________________

Is it OK to leave messages on your home phone? (Circle One) YES NO

Is it OK to leave messages on your cell phone? (Circle One) YES NO

Email address:______________________ Is it OK to send you an email? (Circle One) YES NO

*Please be aware that email might not be confidential (see Informed Consent Agreement).

Occupation & Employer:____

How did you hear about my practice? Or by whom were you referred?______________________

Emergency Contact Information:

Name:__________________ Phone:__________________ Relationship:__________________

Address:____

Signature:______________________ **Date:**______________ **THANK YOU!!**