ACACIA CENTER FOR HUMAN GROWTH AND DEVELOPMENT, INC.

D. Shaner Gable, Ph.D., H.S.P.P.   Carolyn B. Hines, M.Ed., Ph.D.

Adult Client Information

Date ______________________

Basic Information

Last Name ______________________________ First Name, MI ________________________

Male / Female   Date of Birth _____________________ SS# _________________________

Street Address ____

City _______________________________ State________________ Zip code ______________

Home phone __________________________ Cell phone _______________________________

Employer _________________________________ Work phone _________________________

Primary Care Physician _________________________ Phone ___________________________

Insurance Information

Name of insurance company ____

Name of person who carries insurance ____

Date of birth of insurance carrier ____

Relationship to client ____

Group # _____________________________   ID# __________________________________

Emergency Contact

Name ____ Phone # _______________________

Relationship to client ____

Guardian for adult client (if applicable)

Name ____________________________
Phone # _____________________________

Caseworker (if applicable)

Name _____________________
Phone # ____________________

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Health Information Form

(adult)

Name ____ Date of Birth __________________

Who referred you to Acacia Center? ____

Current Problems

Why are you coming to Acacia Center? (check all that apply)

Depression / Anxiety ____ Substance abuse problems ____ Eating disorders ____
Gambling problems ____ Work problems ____ Family problems____
Relationship problems ____ Social problems ____ Financial problems ____
Legal problems ____ School problems ____ Other_____
Please describe ____

____

Check any *feelings* or *thoughts* you have had in the *past month*:

Sadness / Depression ____ Frequently tearful ____ Loss of interest/pleasure ____
Fatigue/ tired ____ Feeling hopeless ____ Low self-worth ____
Excessive worries ____ Guilt/shame ____ Obsessive thoughts ____
Nervousness/anxiety ____ Panic attacks _____ Excessive fears _____
Irritability/anger ____ Headaches ____ Persistent aches/pains ____
Memory problems ____ Other ____
Please describe ____

____

How much do your problems affect your life? Little or none / moderately / severely

How well do you sleep at night? Good / fair / poor How many hours?______________

Have you had any *recent* thoughts about: Not wanting to live ____ Hurting yourself ____
Hurting someone else ____ None of these ____

Have you *ever*: Made a suicide attempt ____ Hurt yourself on purpose ____
Overdosed, on purpose or by accident ___ None of these ____

Past Psychiatric History

List any other counseling/treatment you have had for emotional or alcohol/drug problems, either inpatient or outpatient.

Where	Reason	Date

Family Psychiatric History

List any mental health diagnosis in your family.

Diagnosis **family member**

______________________ ______________________________

______________________ ______________________________

______________________ ______________________________

______________________ ______________________________

Medical Information

Do you have any serious health problems? Yes / No

Please explain ____

____

How much do your health problems affect your life? Little or none / moderately / severely

Are you allergic to any medicines? Which medicines? ____

Have you ever overused prescription medications? Which medicines? __________________________________

Do you have problems seeing ____ hearing ____? If so, please describe ________________________________

Do you smoke cigarettes / cigars / pipes? How much per day? ____

Are you involved in any behaviors which would put you at a high risk for contracting a communicable disease?

use of drugs by injection ___ unprotected sex with more than one partner ____ other________________

Have you tested positive for a communicable disease? Hepatitis ____ TB____ HIV/AIDS ____other________

For female clients Is there any possibility that you are pregnant? Yes / No

Have you had any serious accidents or illnesses in the past? Please describe______________________________

School

Highest grade you have completed?____ Were you ever in Special Education? Yes / No

What type? ___________________________ For how long?______________________

Overall, how would you describe your school experiences? Good / Fair / Poor

Daily Activities

Do you have a job? Yes / No Where?_____________________________ How many hours per week ________

How long at this job?________________ How many jobs have you had in the past 5 years?________________

Have you had problems at work? Yes / No

Describe ____

Are you satisfied with your current job? Yes / No

If you are not working, why not?____

Do you have difficulty preforming any of the following daily living tasks? (check all that apply)

Performing personal care (bathing, dressing, etc.) ____ Cooking and cleaning living area ____

Shopping and getting necessary supplies ____ Managing money___ Using transportation ____

Finding/using community resources ____ Managing housing needs ____ Other ___________________

Do you have problems with any of the following? (check all that apply)

Losing track of time ____ Forgetting recent events ____ Feeling someone is out to get you _____

Learning new tasks____ Sticking with tasks ____ Seeing/hearing things others don't ____

Communicating with others ____ Reading/doing math ____ Feeling controlled by others ____

Other ____

Who do you spend your free time with? Family ____ Friends ____ Coworkers ____ Self____ Others _______
Do you find your activities to be enjoyable and satisfying? Yes / No Explain ___________________________
Do any of your activities involve alcohol/drug use? Yes / No Which ones? _____________________________
Are you involved in any religious/spiritual activities? Yes / No Describe _______________________________

Relationship Information

Marital status: Never married / Married / Separated / Divorced / Widowed
Do you have children? Yes / No If so, how many?_____ What are their ages?________________________
If not married, are you in a relationship? Yes / No For how long?_______ Satisfied in relationship Yes / No
In your relationships, has there ever been: Verbal abuse ____ Physical abuse ____ Sexual abuse ____

Home Information

Where you live, do you: Own/Rent ____Live in someone else's home____Homeless____Other ____________
Is your living situation satisfactory or do you find it stressful?
Satisfied/ no stress _____ Moderately satisfactory/stressful ____ Very dissatisfied or stressful ______

Support

Please describe your family/interpersonal relationships (check all that apply)
You have family/friends that are able to help and support you ____
Don't have family/friends who help of support you ____ Have family/friends, but don't get along ____
Your family/friends have a bad influence on you ____
You have trouble making friends / getting close to others ____ You have trouble with people you work with ____ You don't have much interest in others ____ Other ______________________________

Traumatic Experience

Are there parts of your life or environment that are dangerous for you? (check all that apply)
You are verbally/emotionally abused _____ You are threatened by someone ____
Someone is physically violent towards you _____ Your living situation is dangerous ____
You have a history of being victimized (exploited, robbed, mugged) _____________________________

Aggression

Do you have trouble controlling your temper or do you act out at times? (check all that apply)
You get into conflicts at home or work ____ Other people are scared of you____
People think you act strangely at times ____ You have been known to threaten others ____
You are sometimes sexually aggressive ____ You have destroyed property ____

Alcohol / Drug Use / Gambling

Please check if you have EVER used any of the following, and *circle* any you have used in the past 30 days:
Alcohol ____ Marijuana ____ Tranquilizers (Valium, Xanax, etc.) ____ Cocaine ____ Narcotics ____
Methamphetamine (crank) ____ Hallucinogens (LSD,PCP)____ Diet pills ____ Sleeping pills _______
Other ____
Have you used any in the last 48 hours? Yes / No What and how much? ________________________________
Do you think you may have a problem with alcohol or drugs? Yes / No
You sometimes drink/use more than you intend to. Yes / No
You have trouble sleeping if you don't drink /take something. Yes / No
You have had other people tell you to quit or cut down your use. Yes / No Who?________________________
You sometimes gamble away more money than you intend to or can afford. Yes / No

You have felt guilty about what has happened when you gambled. Yes / No

Family History

How would you describe your childhood? Good / Fair / Poor

Please check if you experienced any of the following as a child:

Emotional abuse___ Physical abuse___ Sexual abuse___ Neglect___ Parent or brother/sister died ____

Lived outside parent's home for extended period of time____ Emotional or alcohol/drug problems in family ____

Legal problems in family ____ Other ____

Military

Have you ever been in the military? Yes/No Honorable discharge /Dishonorable discharge / Medical discharge

How would you describe your military experience? Good / Fair / Poor

Branch:____________-Highest Rank______________Rank at Discharge:____________

Deployments (where and dates)_________________________________

Legal

Are you currently facing legal charges? Yes / No If yes, then what charges?___________________________

Are you currently on probation, parole, or work release? Probation/parole officer's name _________________________

List arrests: ____

Are you involved in any civil cases? Explain ____

Traumatic Experiences

Have you ever experienced or witnessed a traumatic event? Yes / No

If yes, describe ____

Have you ever been physically or sexually assaulted? Yes / No

If yes, describe ____

Have you had a child die or a child involved in a serious accident? Yes / No

If yes, describe ____

Nutritional Information

Do you consider yourself overweight? _____ Underweight? _____ By how many pounds? _______

Has your weight changed in the last six months? Yes/No Has it increased___ Decreased___ How many pounds? ___

Are you currently on a diet? Yes / No If so, what kind of diet?___________________________________

Do you have problems with:

Chewing____ Vomiting____ Swallowing____ Nausea____ Binge eating ____

Purging(vomiting on purpose)____ None ____ Other _________________________________

Please list three of your strengths.

1.

2.

3.

Please list three goals you have for your treatment.

1.

2.

3.

Other History Information

____
____
____
____
____
____
____

Signature ____ Date _____________________________

THIS FORM WAS COMPLETED BY: PATIENT ____ THERAPIST ____ OTHER____________
REVIEWED BY THERAPIST ____