Hope and Healing of Pinellas

Adult Information Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Primary phone: _____ e-mail: _____

May we leave messages when calling you? y___ n___

Check here to consent to texting or email to confirm or cancel appointments_____

May we verify your insurance benefits? y____ n____ May we file insurance claims on your behalf? y___ n___

B. Referral: Who can we thank for referring you?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

Health Providers:

Are you currently seeking another therapist of psychiatrist?

Therapist name: _____ Phone: _____

Psychiatrist name:_____Phone:_____

Medications:_____

Mental health diagnosis:_____

Any physical health diagnosis?_____

Employer/Occupation: _____

Education: _____

I. Family-of-origin history:

How would you describe your family while growing up? Relationship with parent(s)?

_____

_____

_____

Describe your relationships with siblings_____

J. Did you experience any physical, emotional or sexual abuse or neglect as a child? y___ n____
Briefly describe_____

Were any of your caregivers addicted? If yes, who and what substance?_____

Do you have or think you may have a problem with substance use? please describe_____

Is there a history of mental Illness In your family? Please describe_____

Current relationship status: __single __married __ partnered __divorced __separated

Who are your main sources for support?

_____

_____

What are your strengths?

_____

_____

What is your main reason(s) for seeking counseling?

_____

_____

_____

If you have taken part in counseling before, let us know what was helpful, and also not helpful, for you_____

_____

_____

Thank you for taking the time to complete this form