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A Vibrant Mind, LLC
Adult Information Form

Client Information

Name _____ m / f Age _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone _____ Email _____
Occupation _____ Highest Level of Education _____
Relationship Status Single Living Together Married Widowed Separated Divorced

Medical Information

Please describe any serious illnesses, accidents, or injuries _____

Please list **any** medication that you are currently taking and what its for (where applicable give the name of the prescribing physician)

Describe what type and how much alcohol you drink per week _____

Indicate any drugs you use Marijuana Hallucinogens Other _____

Has anyone complained about your alcohol or drug use? Yes No

Mental Health Information

Please describe your personal struggles and concerns and the reasons that you are seeking help at this time

Are you currently in counseling elsewhere? Yes No

Have you had previous counseling? Yes No

Please check any current or past problems

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Health Problems | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Disordered Eating |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Communication Problems | <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Marital problems |
| <input type="checkbox"/> Job Related Problems | <input type="checkbox"/> Parent/Child Conflict | <input type="checkbox"/> Financial Concerns | <input type="checkbox"/> Separation or Divorce |
| <input type="checkbox"/> Legal Problems | <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Illness | <input type="checkbox"/> Child Rearing |
| <input type="checkbox"/> Caretaking | <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Compulsive Behavior | <input type="checkbox"/> Death of a Loved One |
| <input type="checkbox"/> Sexuality | <input type="checkbox"/> Other _____ | | |

Describe the strengths you have shown in adjusting to past difficulties _____

Describe what matters most to you _____

What else would you like me to know _____
