FAULKNER UNIVERSITY

CENTER FOR THERAPY AND RESEARCH

Mental Health Counseling Services
Faulkner Center for Therapy and Research
Adult Case History

Please complete the form to the best of your ability and return it prior to your evaluation appointment. We will review this form with you and help you complete it during your visit.

Legal Name: _____ **Today's Date:** _____

Age: _____ **Birthdate:** _____ **Sex:** ❑ Male ❑ Female

Emergency Contact

Name: _____ Phone #: _____

Home Address: _____

_____

FAMILY RELATIONSHIPS

What is your current marital status?

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ In a Relationship

Children present in home:

Names & Ages:

_____

_____

_____

_____

_____

In general, how would you describe your relationship with your family? (check all that apply)

❑ Good ❑ Poor ❑Stressful ❑Close ❑ Distant

In general, how would you describe your relationships with other supportive people (friends, extended family, etc)? (check all that apply)

❑ Good ❑ Poor ❑Stressful ❑Close ❑ Distant

EXPLANATION OF CONCERNS

Please describe what brings you in today:

_____

_____

_____

_____

How long have you been experiencing this problem?
❑ less than 30 days ❑ 1-6 months ❑ 1-5 years ❑ 5+ years

How does this problem interfere with your day-to-day functioning?

_____

_____

_____

_____

Please check any of the following that you have experienced in the past 30 days:

❑ Depressed mood	❑ No motivation	❑ Sleep too much	❑ Sleep too little
❑ No energy	❑ Irritability	❑ Concentration Problems	❑ Panic attacks
❑ Anxiety	❑ Constant worry	❑ Feeling worthless	❑ Hopelessness
❑ Guilt	❑ Can't sit still	❑ Too much energy	❑ Sadness
❑ Fearfulness	❑ Poor Memory	❑ Thoughts of death	❑ Nightmares

Have you had any suicidal thoughts recently? ❑ Yes ❑ No
If yes, how often? ❑ Frequently ❑ Sometimes ❑ Rarely

Have you ever had suicidal thoughts in your past? ❑ Yes ❑ No
If yes, how often? ❑ Frequently ❑ Sometimes ❑ Rarely

Have you ever attempted suicide? ❑ Yes ❑ No
If yes, how old were you at the time?

Have you ever been hospitalized for a mental health issue? ❑ Yes ❑ No
If yes, how old were you at the time?

SUBSTANCE USE HISTORY

At any time in the last 30 days, have you felt that you should reduce or stop:

Smoking cigarettes? ❑ Yes ❑ No ❑ Do not use

Alcohol use? ❑ Yes ❑ No ❑ Do not use

Drug use? ❑ Yes ❑ No ❑ Do not use

Has drinking or taking drugs caused you any problems with work, friends, family, or your health?

Currently? ❑ Yes ❑ No

Within the past year? ❑ Yes ❑ No

Was drinking or using drugs a problem for you at one point in your life but not a problem now?

❑ Yes ❑ No ❑ Never used/ drank

Has anyone ever expressed concern about your drinking/ drug use?

❑ Yes ❑ No ❑ Do not use

If yes, please elaborate.

_____

_____

_____

_____

PAST/ CURRENT MENTAL HEALTH

Have you ever been to therapy before? ❑ Yes ❑ No

If yes, how old were you? _____

_____

Have you ever been diagnosed with a mental health issue? ❑ Yes ❑ No

If yes, what? _____

_____

_____

_____

Are you currently taking any medications? ❑ Yes ❑ No

If yes, what? _____

_____

_____

_____

Are you aware of any family members who have a history of mental health issues? ❑ Yes ❑ No

If yes, please elaborate. _____

_____

_____

_____

What would you say are your goals for therapy? If treatment were to be successful, what would be different?

_____

_____

_____

_____

List your strengths and what you like most about yourself.

_____

_____

_____

_____

List areas you feel you need to develop.

_____

_____

_____

_____

What are some ways you cope with stress and difficult situations?

_____

_____

_____

_____