

CONFIDENTIAL

Name: _____ Social Security Number: _____
Date: _____

FRASER CENTER
Initial Information for Adults

Please answer the following questions as best you can. You can write on the back of this form if you need to. If you would prefer not to write down the answer to a question, please leave that question blank and discuss it with your therapist. All your answers are confidential, to the extent allowed by law.

Name of Person Completing This Form: _____

Current Problems:

Why are you coming to the Center right now? _____

Has anything happened to make you seek help *now*? _____

Please check any problems you are having right now and/or have had in the past:

	Now	Past		Now	Past
Problems sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Less or more hungry than usual	<input type="checkbox"/>	<input type="checkbox"/>
Problems concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Crying spells	<input type="checkbox"/>	<input type="checkbox"/>	Feeling hopeless	<input type="checkbox"/>	<input type="checkbox"/>
Feeling depressed	<input type="checkbox"/>	<input type="checkbox"/>	Feeling anxious or nervous	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of suicide	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of hurting others	<input type="checkbox"/>	<input type="checkbox"/>
Relationship problems	<input type="checkbox"/>	<input type="checkbox"/>	Legal problems	<input type="checkbox"/>	<input type="checkbox"/>
Problems with alcohol	<input type="checkbox"/>	<input type="checkbox"/>	Problems with drugs	<input type="checkbox"/>	<input type="checkbox"/>
Job problems	<input type="checkbox"/>	<input type="checkbox"/>	Problems with past	<input type="checkbox"/>	<input type="checkbox"/>

Please list any medical problems you have now: _____

Please list any allergies you may have; if none, please write "None": _____

Please list any prescription medicines you are taking now, including the name of the provider prescribing them and the dosages: _____

Please list any other-the-counter medicines you are taking now, including the dosages: _____

Please list any past medical treatment you have had:

Type of Treatment	Provider	Dates of Treatment	Did it help?

You may list additional medical treatment on the back of this form.

CONFIDENTIAL

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Please list any past behavioral treatment you have had, including hospitalizations:

Type of Treatment	Provider	Dates of Treatment	Did it help?

You may list additional behavioral treatment on the back of this form.

Family History:

How old is your mother? _____

What type of work does/did she do? _____

How old is your father? _____

What type of work does/did he do? _____

Are your parents married to each other now? _____

How many brothers/sisters do/did you have? _____

How old are/were they? _____

Have any members of your family had any mental or nervous problems? Yes No

If yes, whom and what kind of problems? _____

Have any members of your family had any problems with alcohol or drugs? Yes No

If yes, whom and what kind of problems? _____

Childhood History:

As far as you know, did your mother have any problems while she was pregnant with you? _____

Were there any problems that you know of at the time of your birth? _____

Did you have any problems with any of the following?

	Yes	No		Yes	No
Smiling	<input type="checkbox"/>	<input type="checkbox"/>	Sitting up	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	Talking	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Training	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>

As a child, did you experience any major illnesses, losses or separations? _____

How far did you go in school? _____

What kind of grades did you get in school? _____

Did you have any academic problems in school? _____

CONFIDENTIAL

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Were you ever in Special Education classes? _____
 Were you ever told you had a Learning Disability? _____
 Did you repeat any grades in school? _____
 Did you have any conduct or behavior problems in school? _____

Were you ever abused as a child?

	Yes	No	Maybe	Prefer not to answer
Verbal abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Did you have many friends as a child? _____
 When did you first begin to date? _____
 If you have been married, when did you first get married? _____
 If you have been married, how many times? _____

Please list any children you have:

Name	Age	Sex	Occupation	Living with you?

You may list additional children on the back of this form.

Current Life Situation:

What type of work do you do? _____
 How long have you been at your current job? _____
 How many jobs have you had in the last ten years? _____
 Have you ever been arrested? Yes No
 If you have been arrested, when and for what? _____

Have you ever gotten into trouble because of your temper or violence?

Yes No

Have you ever gotten a DUI? Yes No

Do you smoke cigarettes? Yes No If yes, how much? _____

Do you drink coffee? Yes No If yes, how much? _____

When did first try alcohol? _____
 When did you first get drunk? _____
 How much do you drink in a week right now? _____

CONFIDENTIAL

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- Have you ever decided to cut down on your drinking? Yes No
Have you ever been annoyed by questions about your drinking? Yes No
Have you ever felt guilty about your drinking? Yes No
Have you ever needed a morning eye-opener? Yes No
Do you believe that you have a problem with drinking? Yes No

When did you first try marijuana? _____
How much do you smoke in a week right now? _____

Do you believe that you have a problem with marijuana? Yes No

What drugs do you use now or have used in the past?

	Now	Past		Now	Past
Cocaine or "crack"	<input type="checkbox"/>	<input type="checkbox"/>	Amphetamines or "speed"	<input type="checkbox"/>	<input type="checkbox"/>
LSD or "acid"	<input type="checkbox"/>	<input type="checkbox"/>	Depressants or "downers"	<input type="checkbox"/>	<input type="checkbox"/>
Sniffing chemicals	<input type="checkbox"/>	<input type="checkbox"/>	Heroin or methadone	<input type="checkbox"/>	<input type="checkbox"/>
Others (list after)	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Are you involved in organized religion? Yes No

Do you consider your spiritual life to be important to you? _____

Are there any people that you talk to about your problems? _____

Who do you feel is "on your side" in life? _____

Goals:

What three things would you like to change by coming to the Center?

1. _____
2. _____
3. _____

How long do you think it will take to make these changes? _____

What else do you think is important for you counselor to know about you?
(Continue on the back of this form if you need more space.)

<p>For Office Use Only Provider Signature verifying this form has been reviewed: _____ Date of provider review: _____</p>
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