KELLY WEDEVEN, PLLC

1843 S Broadway Ave, Suite 103
Boise, ID 83706
Phone: 208-841-2318 www.kellywedeven.com Fax: 888-977-1549

ADULT INFORMATION FORM

Name _____ Date of Birth _____ Age _____ Gender _____

PRESENTING CONCERN/S:

_____

_____

_____

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with your doctor? YES NO Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever attended counseling before and what did you work on?

_____

_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Do you participate in regular exercise? (Circle One) YES NO

Describe any important medical history, chronic ailments, or other health problems you experience:

_____

_____

_____

SCHOOL, FAMILY AND SOCIAL HISTORY

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____ Year(s) _____

(2) School(s) _____ Year(s) _____

(3) School(s) _____ Year(s) _____

Describe your current working environment: _____

How would you describe your current support network? (friends, relatives, etc.): _____

_____

_____

Do you have a particular spiritual practice or belief that you would like incorporated in your treatment?

_____

What activities or hobbies do you participate in?

_____

Where were you born and raised? _____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times

Describe your relationship with your mother while growing up and currently: _____

_____

_____

Describe your relationship with your father while growing up and currently: _____

_____

_____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to drug abuse/alcohol abuse, domestic violence, trauma (sexual,physical, emotional, neglect) or other: _____

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

_____

MARITAL HISTORY

Marital status: ___ Single/never married ___ Married ___ Separated ___ Divorced ___ Widowed ___ Living w/someone

If currently married or living w/ someone partner's name & how long together? _____ _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SYMPTOMS SCREENER

Over the past two weeks have you experienced…	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	□	□	□	□
2. Feeling down, depressed, or hopeless	□	□	□	□
3. Trouble falling or staying asleep, or sleeping too much	□	□	□	□
4. Feeling tired or having little energy	□	□	□	□
5. Poor appetite or overeating	□	□	□	□
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down	□	□	□	□
7. Trouble concentrating on things, such as reading the newspaper or watching television	□	□	□	□
8. Moving or speaking so slowly that other people could have noticed? – or the opposite – being so fidgety or restless that you have been moving around more than usual	□	□	□	□
9. Thoughts that you would be better off dead or hurting yourself in some way	□	□	□	□
How much distress would you say these symptoms caused you?	**Mild** □	**Moderate** □	**Severe** □	

Over the past two weeks have you experienced…	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge?	□	□	□	□
2. Not being able to sleep or control worrying?	□	□	□	□
3. Worrying too much about different things?	□	□	□	□
4. Trouble relaxing?	□	□	□	□
5. Being so restless that it is hard to sit still?	□	□	□	□
6. Becoming easily annoyed or irritable?	□	□	□	□
7. Feeling afraid, as if something awful might happen?	□	□	□	□
If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not at all** □	**Somewhat difficult** □	**Very difficult** □	**Extremely difficult** □

Has there ever been a period of time when you were not your usual self and…	**Yes**	**No**
1. You felt so good or hyper that other people thought you were not your normal self or were so hyper that you got into trouble?	□	□
2. You were so irritable that you shouted at people or started fights or arguments?	□	□
3. You felt much more self-confident than usual?	□	□
4. You got much less sleep than usual and found you didn't really miss it?	□	□
5. You were much more talkative or spoke much faster than usual?	□	□
6. Thoughts raced through your head or you couldn't slow your mind down?	□	□
7. You had much more energy than usual?	□	□
8. You were much more active or did many more things than usual?	□	□
9. You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	□	□
10. You were much more interested in sex than usual?	□	□
11. You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	□	□
12. Spending money got you or your family into trouble?	□	□
If you checked YES for more than one of the above, have several of these ever happened during the same period?	**Yes** □	**No** □

Has there ever been a period of time when you were not your usual self and…	**Yes**	**No**
1. Have had nightmares about it or thought about it when you did not want to?	□	□
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	□	□
3. Were constantly on guard, watchful, or easily startled?	□	□
4. Felt numb or detached from others, activities, or your surroundings?	□	□
How much distress would you say these experiences caused you?	**Mild** □ **Moderate** □ **Severe** □	

ADDITIONAL INFORMATION

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

GOALS

Please list your therapy goals:

_____

_____

_____

_____