



ADULT BACKGROUND INFORMATION

Welcome to New Leaf Clinic. Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Please ask for assistance, if needed. Your counselor will discuss your responses with you Interview.

Your Name: _____ Today's Date _____

Last First MI

Home Phone: _____ (Okay to call? Yes No Okay to Leave Message? Yes No)

Work Phone: _____ (Okay to call? Yes No Okay to Leave Message? Yes No)

Cell Phone: _____ (Okay to call? Yes No Okay to Leave Message? Yes No)

Address: _____
Street City State Zip

* GENERAL INFORMATION *

Gender: Male__ Female__ Date of Birth ___/___/___ Age___ SS# _____

Ethnicity:

Africa American__ Bi-racial__ Hispanic/Latin__

Asian__ Caucasian__ Native American__ Other _____

Emergency contact: _____
Last, First Relationship Phone

How were you referred to our clinic? (Check those that apply):

Counselor/Psychologist/Psychiatrist__ School personnel__ Self__

Flyer__ Friend or Co-Worker__ Other _____

Educational Level:

Some College _____ College Graduate _____ Master's Degree _____

Ph. D. Degree _____ Professional Degree _____

* FAMILY INFORMATION *

Marital Status: Married__ Divorced__ Separated__ Single__ Widowed__

If divorced, circle the number which best describes your relationship with your former spouse.

Hostile Frustrating Friendly
1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Are you currently involved in a custody dispute: Yes No (If yes, explain) _____

Current living arrangements:

Family of origin _____

Relatives _____

Single _____

Married _____

Roommate(s) _____

Single parent w/children _____

Married w/children _____

Significant other _____

Other _____

If married with children, list your family, beginning with the oldest member and include yourself

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*** HEALTH ***

Primary Care Physician: _____
Name

Address _____ Phone _____

Date of LAST complete physical: _____

Are you currently in counseling elsewhere? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency _____

Phone _____ Dates of Service _____ (beginning - ending)
Name Address

Have you ever been hospitalized for mental health concerns: Yes No

If yes please explain: _____

If you have ever received a mental health-related diagnosis, or have taken medication for a mental health-related condition, please fill out the following (if extra space is needed, attach a separate sheet):

Diagnosis Date of Diagnosis Name of medication Dosage

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If you have received a diagnosis, who gave the diagnosis?

Counselor/Psychologist ___ Family Physician ___ Psychiatrist ___ School ___ Other _____

Name: _____ Phone #: _____

What (if any) other medication(s) are you currently taking?

Medication Dosage? Reason?

*** CURRENT CONCERNS ***

Please list all of the concerns you currently have about yourself as a parent and your relationship with your child(ren). Please be specific.

How long have you had these concerns? _____

How have you attempted to deal with these concerns in the past? _____

*** FAMILY ATMOSPHERE ***

Family of Origin Atmosphere: Circle the number that best describes how you viewed your family while you were growing up:

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent
Hardly any support	1	2	3	4	5	Considerable support

Your Current Family Atmosphere: Circle the number that best describes how you view your current family:

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent
Hardly any support	1	2	3	4	5	Considerable support

What do you enjoy most about your child(ren)? _____

What do you find most difficult about your child(ren)? _____

Anything else you think we need to know? _____