Nancy A. Vierra, MFT
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**ADULT HISTORY**

**Date_____**

**Name_____ Cell_____**

**Home Address_____Home Phone_____**

**Workplace_____Duration_____**

**Work Phone_____Address_____**

**Relationship Status_____ (married, divorced, single, separated, widowed)**

**Gender Male____Female____ Other____Date of Birth_____**

**Ethnicity_____ Religious Preference_____**

**How long have you lived in the Bay Area?_____**
**How long in your current location?_____**
**With whom do you live?_____**

**Source of Referral: Name_____**
**(if a medical practitioner, a release is needed from you for this therapist to exchange information with this person---please bring this to my attention.)**

**Do you have any children?_____Y/N How many?_____**

**Names/Ages_____**

**With whom do your children live?_____**

**That address_____**

**That phone number (if different from your own)_____**

**Reason for seeking treatment?_____**

**_____**

**How long have you been feeling this way?_____**

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**Why are you pursuing therapy now?**_____

_____

**Is treatment a result of any legal action?**_____

_____

**Have you ever felt like hurting yourself or ending your life? Yes_____ No_____**

_____

**Previous suicide attempts & methods**_____

_____

_____

## Psychosocial

**Are your parents living?**
**Mother Yes_____ No_____ Date of Death & Cause**_____
**Father Yes_____No_____** _____
**Other Parental Figure? Yes____ No____ Name**_____
**How long have they been in your life?**_____
**Other Comments on Family?(Parents married, divorced and when?)**
_____
_____
**Spouse or Partner Name**_____**Age**_____

**Sibling(s): Name(s), Age(s), & Gender(s)**_____
_____

_____

**What recent stressors have you experienced? (death, auto accident, job, friends, health)**_____

_____

**Please describe your relationship with your family of origin**_____

_____

_____

_____

**How have your significant relationships ended in the past?**

_____

_____

_____

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**What are your strengths? Please List**

**Please list your key support persons including social service providers**

**Highest Level of Education/Please Describe**

**Hobbies/Favorite Past-times**

**Legal History (arrests, litigations, charges, sentences, court orders)**
**Describe**_____

## Substance Use

**How often do you drink and what do you choose to drink?**

**How much do you usually drink per sitting?**_____
**How often do you drink to the point of being tipsy?**_____
**Which best describes any problem(s) with alcohol?**
**Binges**___ **Job Problems**____ **Sleep Disturbance**____ **Physical Withdrawal**_____
**Hangovers**_____ **DUIs**____ **Blackouts**____ **Medical Complications**_____
**Assaults**_____ **Passing Out**_____ **Change in Tolerance**_____
**Concern over drinking** _____ **Seizure(s)**_____ **Inability to stop after the first drink** _____
**Please circle all substances used in the last 6 months**
**Alcohol** _____ **Marijuana** _____ **Sedatives** _____ **Cocaine** _____ **Opiates**_____
**Hallucinogens** _____ **Heroine** _____ **Ecstacy** _____ **Meth/Speed**_____
**Caffeine** _____ **(number of cups per day)** _____
**Tobacco**_____**(amount per day)**_____
**Other/Please Describe**_____

**Please list all medications or pharmaceuticals that you use**

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**Please list all herbs/supplements and/or vitamins that you use**

**Have you recently lost a significant amount of weight? Yes_____ No_____**
**Describe how or why you lost weight_____**

**List/describe allergies_____**

## Family History

**Family history of drug/alcohol use? Yes____ No_____ Please describe**

**Family history of eating disorder(s) Yes_____ No_____Please describe**

**Family history of sexual abuse? Yes____No___or physical abuse? Yes___No____**
**Please describe_____**

**Family history of domestic violence? Yes_____No_____**
**Please describe_____**

**Have the police ever been involved with your family of origin? Yes____ No_____**

**Please describe_____**

## Medical Information

**Who is your primary care physician?_____**

**Date of last physical exam?_____**

**Describe your current medical conditions**

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**History of serious illnesses & hospitalizations**_____

_____

**Allergies** _____

**Family history of health conditions**_____

_____

## Therapy History

**Have you ever been hospitalized for a psychological condition? Yes_____ No____**
**When, where, by whom?**_____

_____

**Have you had previous therapy? Yes_____ No?____ With Whom?**_____

_____

**What did you like about therapy?**_____

_____

_____

**What did you find the most difficult?**_____

_____

**Type of therapy?**_____
**What brought you to that therapy?**_____

_____

_____

**What did you accomplish?**_____

_____

_____

_____

**What was the most helpful aspect of therapy? (style, clinician, homework, humor, etc.)**

_____

_____

_____

**What was the least helpful?**

_____

_____

_____

**How did your previous therapy end?**_____

_____

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**Describe some activities, things, people or environments that positively affect your mood?**_____

_____

_____

_____

_____

_____

**Completed by/Submitted by:** _____

**Date:** _____