20231 Paint Boulevard
Shippenville, PA 16254
(814) 226-1159
Fax (814) 227-2876

850 Leonard Street
Clearfield, PA 16830
(814) 205-4004
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ADULT HISTORICAL INFORMATION

Client Name:_____ DOB:_____

FAMILY OF ORIGIN HISTORY: Date:_____

Relative	Name	Current Age (age at death)	Occupation	MH, D&A or Criminal Issues
Father				
Mother				
Brother (s)				
Sister (s)				

1). Was your family ever involved with agencies or services while you were growing up:

_____ Yes _____ No

If yes, please explain: _____

_____

RELATIONSHIP/FAMILY HISTORY

Spouse's Name	Spouse's Age At Marriage	Your Age at Marriage	Current Marital Status	Marital Problems

If unmarried, but have had significant long-term relationships answer the following:

Name of Significant Other	Other's Age	Your Age	Relationship Status	Relationship Problems

Children's Name	Biological, Step Or Adopted	Current Age	Other Parent's Name	How often do you see child(ren)

EDUCATIONAL HISTORY:

Date From:	Date To:	Name of School or College	Special Classes (Yes or No)	Behavior Problems (Yes or No)	Did you Complete (Yes or No, if no explain)

WORK HISTORY:

Date From:	Date To:	Name of Employer, Address, Phone Number	Job Title or Duties	Problems on the Job (Yes or No)	Reason for Leaving

MEDICAL HISTORY:

1) Do you have any significant medical issues: ____Yes ____No If yes, please explain issues:

_____

_____

2) Have you ever been diagnosed with an infectious disease: ____ Yes ____ No If yes, please describe diagnosis and treatment regimen:_____

_____

_____

3)Are you currently pregnant: ____ Yes _____ No

4)Do you suffer from any food, drug, or environmental allergies: _____Yes _____No If yes, please describe what you are allergic to and what adverse reactions you experience:_____

_____

_____

Treating Physician's Name	Phone Number	Address	Frequency of Visits

3) Have you ever received any drug or alcohol treatment: ____ Yes ____ No

Date From:	Date To:	Name of Provider, Address, Phone Number	Service Received and Frequency

MENTAL HEALTH HISTORY:

1) Have you ever received any mental health treatment in your lifetime: ____ Yes ____ No

If yes, please answer the following questions:

Date From:	Date To:	Name of Provider, Address, Phone Number	Service Received and Frequency	Your Diagnosis

2) Have you been declared incompetent: _____ Yes _____ No If you answered yes please list:
Guardian's Name:_____ Phone:_____

RELIGIOUS/SPIRITUAL/CULTURAL HISTORY:

1) Do you currently practice any religion or belong to any spiritual organization: ____ Yes ____ No
If yes, please describe: _____
_____

2) Do you currently belong to any cultural organizations or practice any specific cultural beliefs:
____ Yes ____ No
If yes, please describe: _____
_____

LEGAL ISSUES:

1) Are you currently involved in the court system for any criminal or civil proceedings: ___Yes ___No
If yes, explain:_____
_____

2) Have you ever been arrested or charged for a crime: ____ Yes ____ No
If yes, please list charges or crimes and sentences: _____
_____

3) Have you ever been or are you currently involved with probation or parole: ____ Yes ____ No
If yes, please agency name, county address:_____
_____

SOCIAL SUPPORTS:

1) List all the social supports you utilize in your life: _____
_____

2) Do you feel these supports are adequate? ____ Yes ____ No