BROUDY AND ASSOCIATES

Adult Data Form

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to; do the best you can. Thank you!

PATIENT IDENTIFICATION

Name_____ **First Appointment Date**_____

Birth Date_____ **Age**_____ **Sex**_____

Soc. Sec. #_____ **Employer**_____

Religion_____ **Marital Status**_____

Race_____ **Children**_____

Address_____

City_____**State**_____**Zip**_____

Home Phone #_____**Work #**_____

REFERRAL SOURCE
Referral Source_____
Referral Address_____ **Phone #**_____
Do we have your permission to release information to the referring professional when it is appropriate?
Yes_____ No_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME?

_____
_____
_____
_____
_____

ADDITIONAL CONCERNS?

_____
_____
_____
_____
_____

PREVIOUS COUNSELING, HOSPITALIZATIONS, SUBSTANCE ABUSE TREATMENT

Where	In or Out Patient	Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason treatment ended: _____
Have you had a psychiatric or psychological evaluation? _____

What do you expect to gain from treatment at this time?

_____
_____
_____
_____
_____

MEDICAL HISTORY

SURGERIES (List separately) DATE OUTCOME

_____
_____
_____

CHRONIC ILLNESSES (Check all that apply)

	Self	Date of Diagnosis
Diabetes		
Hypertension		
Cancer		
Epilepsy/Seizures		
Asthma		
Hearth Disease		
Headaches/Migraines		
Arthritis		
Thyroid Disease		
Other (List)		

Any history of head trauma or loss of consciousness? (Describe)

ALLERGIES REACTIONS

Medications-

Food-

Environment-

Other-

NO KNOWN ALLERGIES

MEDICATIONS (Prescribed and OTC)

Current (List separately) Dose Date of Initial RX Prescribing MD

_____

_____

_____

Herbal Supplements Dose

_____

_____

_____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationship, job, school, finances, children)

_____

_____

_____

_____

MARITAL HISTORY

CURRENT STATUS: SINGLE_____ MARRIED: _____

SEPARATED-DATE_____ DIVORCED-DATE_____ WIDOWED-DATE_____

PAST MARRIAGE(S) IF ANY DATE_____ DATE_____

SPOUSES NAME OR SIGNIFICANT OTHER_____

ADDRESS (IF DIFFERENT) _____

TELEPHONE #_____

EMPLOYER_____

CHILDREN IN THE HOME:
NAME AGE

_____

_____

_____

CHILDREN OUTSIDE THE HOME:
NAME AGE

_____

_____

_____

FAMILY MEDICAL DATA

(Biological Mother)

Medical problems (specify):

_____

_____

Emotional Problems Y_____N_____ Describe_____

Mental Retardation Y_____N_____ Describe_____

Chronic Disease Y_____N_____ Describe_____

Have any of your biological relatives (not including yourself) ever had problems similar to those you have?

If so, describe _____

_____

(Biological Father)

Medical problems (specify):

_____

_____

Emotional Problems Y_____N_____ Describe_____

Mental Retardation Y_____N_____ Describe_____

Chronic Disease Y_____N_____ Describe_____

Have any of your biological relatives (not including yourself) ever had problems similar to those you have?

If so, describe _____

_____

EDUCATION HISTORY (IF APPLICABLE)

HIGHEST EDUCATIONAL LEVEL COMPLETED_____

LAST SCHOOL ATTENDED_____

DESCRIBE BRIEFLY ANY ACADEMIC SCHOOL PROBLEMS

_____

_____

NOTE ANY PROBLEMS IN DEVELOPMENTAL HISTORY AND COORDINATION

_____

_____

Military History

_____

_____

Ever Any Legal Problems?

_____

_____

_____

SUBSTANCE ABUSE OR ALCOHOL PROBLEMS

Any alcohol or mood altering drugs(s)? **Y**_____ **N**_____

		Amount	Route (Oral, injected, Inhaled)	Frequency	When (Last Used)
Beer	**YES___NO___**	_____	_____	_____	_____
Wine	**YES___NO___**	_____	_____	_____	_____
Liquor	**YES___NO___**	_____	_____	_____	_____
Cocaine	**YES___NO___**	_____	_____	_____	_____
Hallucinogen	**YES___NO___**	_____	_____	_____	_____
Amphetamines	**YES___NO___**	_____	_____	_____	_____
Solvents	**YES___NO___**	_____	_____	_____	_____
Narcotics	**YES___NO___**	_____	_____	_____	_____
Marijuana, Hashish	**YES___NO___**	_____	_____	_____	_____

Any Medical Consequences of Alcohol Abuse?
(circle any that apply)

Blackouts **Shakes** **DT's** **Hallucinations** **Other**

Hepatitis **Pancreatitis** **Cirrhosis** **Seizures**

HAS ALCOHOL OR DRUG ABUSE LEF TO LEGAL PROBLEMS INCLUDING DUI?

Y_____ N_____

Describe_____

_____

ANY PREVIOUS TREATMENT FOR ALCOHOL OR DRUG ABUSE OR DEPENDENCE?

Y_____ N_____

When? _____ Where? _____

PREVIOUSLY ATTENDED AA, NA, OR CAMEETINGS? Y_____ N_____

When? _____

ANY DAMILY HISTORY OF ALCOHOL OR DRUG ABUSE? Y_____N_____

Who? _____

Caffeine use per day (caffeine is in coffee, tea, sodas and chocolate)

_____

_____

Nicotine use per day, past and present. (Nicotine is in cigarette, cigars, and tobacco chew)

_____

_____

PLEASE SIGN AND DATE:

_____

Signature **Date**

_____

AGENCY USE ONLY

Reviewed by:

_____

Therapist's Signature