YOUNG ADULT HISTORY FORM

Family Psychology Associates
727.725.8820
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NAME: _____ DATE OF BIRTH: _____ AGE: _____

SEX: _____ MOBILE PHONE: _____ HOME PHONE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EDUCATION: _____

MARITAL STATUS:_____ DATE(S) MARRIED: _____ DATE(S) DIVORCED: _____

CHILDREN/AGES: _____

PRESENTLY LIVING WITH: _____ REFERRED BY: _____

Please state your reason for contacting Family Psychology Associates:

_____

_____

Please list previous mental health professionals whom you have consulted:

_____

_____

Please list any medications you are presently taking:

_____

_____

Please list any medications you have taken in the past:

_____

_____

Who is your family doctor? _____

When did you last consult your doctor? _____

MEDICAL HISTORY

Please list any complications that occurred during your birth? _____

_____

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How were you described as an infant? _____

_____

Please describe how well you mastered developmental milestones. _____

_____

How many accidents did you have as a child? _____

_____

Did you have a history of frequent ear infections, allergies or asthma? If so, please describe.

_____

Besides usual childhood illnesses, please list your medical problems which have received treatment:

_____

Have you had any adverse reactions to medications? If so, please list them. _____

_____

Have you had any of the following problems:

☐ Hypothyroidism	☐ Hyperthyroidism	☐ Seizures	☐ Anxiety or Panic Attacks
☐ Depression	☐ Compulsive Rituals	☐ Mania	☐ High Need for Stimulation
☐ Alcohol Abuse	☐ Other Substance Abuse	☐ Excessive Eating	☐ Excessive Caffeine Use
☐ Anorexia	☐ Bing Eating & Purging		

Other Addictions (i.e., cigarettes, gambling) _____

FAMILY HISTORY

Please list any relatives (grandparents, parents, aunts, uncles, cousins, or children) who have had any of the following problems:

Hyperactivity _____ Learning Disabilities_____

Depression _____ Anxiety _____

Obsessions _____ Manic-Depression _____

Alcoholism _____ Thyroid Problems _____

Substance Abuse _____

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Please list any relatives who have received medication from a psychiatrist and list the medications:

_____

EDUCATIONAL HISTORY

How was your initial adjustment to school? _____

Were you ever retained? If so, what year? _____

Were you ever place in a special education class? If so, please describe. _____

What were your elementary school report cards like so far as the following are concerned:

Grades _____

Activity Level _____

Ability to Work Independently _____

Ability to Use Time Wisely _____

Completion of Assignments on Time _____

What were your middle school & high school report cards like?

Grades _____

Organization Skills _____

Ability to Complete Long-Term Projects _____

Completion of Assignments on Time _____

Consistency of Effort _____

Describe your college experience so far as the following are concerned:

Study Habits _____

Ability to Recall Material _____

Amount of Procrastination _____

Organizational Skills _____

Grade Point Average in College Major _____

Grade Point Average in Other Required Courses _____

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WORK HISTORY

Do you find it difficult to find or keep a job? If so, please explain. _____

_____

How well do you get along with other employees? _____

_____

How well do you get a long with your supervisor?_____

_____

Do you feel that your job is challenging enough? _____

Do any of the following interfere with your work performance?

Procrastination _____

Disorganization _____

Forgetfulness _____

Angry Outbursts _____

Anxiety Attacks _____

Difficulty Finishing What You Start _____

Boredom _____

If you could, how would you change your current job? _____

_____

RELATIONSHIP HISTORY

Have you found it difficult to keep friends? If so, please explain. _____

_____

Do you find it hard to remain interested in your partner or mate? If so, please explain. _____

_____

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Do you find it difficult to communicate clearly with others? Do you often feel misunderstood? If so, please explain. _____

_____

Please describe the ways in which you typically deal with your feelings

Ignore them _____ Get angry _____

Blame others _____ Withdraw _____

Exercise _____ Drink/use Drugs _____

Work Longer _____ Explain them away _____

If you are a parent, please respond to the following:

Amount of time with kids each day _____

Number of arguments each week _____

Amount of consistency with kids _____

Number of arguments with spouse about parenting each week _____

How would your family and friends describe you? _____

_____

ADDITIONAL INFORMATION

What are the 3 most important things you want to accomplish as a result of counseling?

1. _____
2. _____
3. _____

What are you most proud of in yourself? _____

_____

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What do you not want to have to change? _____

_____

What have you already tried that does not seemed to have helped? _____

_____

What else would you like to add that has not yet been covered? _____

_____

What questions would you like me to try and answer for you? _____

_____

Signed: _____ Date: _____

Signed: _____ Date: _____
(parent or significant other)