LEGACY Consortium
Inspiring Greatness | Changing Legacies

Adult Self-Report Form

Please provide the following information.
Services are provided for couples, families, adults, adolescents and children. Couples please complete a separate form for each spouse.

Chief Concern

Please describe the main difficulty that has brought you to see me:

Present relationships

Describe how you get along with your spouse or partner?

Describe how you get along with your children?

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

Please indicate which type of treatment (circle one): Inpatient Outpatient Both
If yes, please indicate:

When **For What?** **Was it helpful?**

Name of Clinic/Therapist:

Contact Number:

Email Address:

When **For What?** **Was it helpful?**
Name of Clinic/Therapist:

Contact Number:

Email Address:

If you enter treatment with me for psychological problems, may I tell your *therapist* so that he/she can be fully informed and we can coordinate your treatment? Yes No

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When	**For What?**	**Was it helpful?**

Name of Psychiatrist:

Contact Number:

Email Address:

If you enter treatment with me for psychological problems, may I tell your *psychiatrist* so that he or she can be fully informed and we can coordinate your treatment? Yes No

Your Medical Care (From whom or where do you get your medical care?) **Clinic name:**

Phone:

Doctor's name:

Address:

If you enter treatment with me for psychological problems, may I tell your *medical doctor* so that he or she can be fully informed and we can coordinate your treatment? Yes No

Are you currently taking medications (prescribed and over the counter) for medical problems? (non-psychatric) Yes No If yes, please indicate:

Name of Medication	What is it for?	Is it helpful?

List of Current Concerns &/or Symptoms

Please check any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use
ambition	anger	anxiety
appetite	being a parent	bowel trouble
career choices	children	compulsions
compulsivity	concentration	confidence
depression	divorce	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	fetishes
finances	friends	guilt
headaches	health problems	inferiority feelings
insomnia	loneliness	making decisions
marriage	memory	my thoughts
nervousness	nightmares	obsessive thinking
overweight	painful thoughts	panic attacks
phobias	relationships	sadness
self-esteem	separation	sexual problems
short temper	shyness	sleep
stress	suicidal thoughts	work
headaches	self-harming	spirituality

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

Marriage / Relationship:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Family:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Job/school performance:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Friendships:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Financial situation:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Physical health:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Anxiety level / nerves:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Mood:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Eating habits:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Sleeping habits:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Sexual functioning:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Alcohol / drug use:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Ability to concentrate:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

Ability to control anger:

1 - No effect 2 – Little effect 3 – Some effect
4 – Much effect 5 – Significant effect Not Applicable

LEGACY Consortium
Inspiring Greatness | Changing Legacies

Substance Use

Please use the chart below to describe your use of drugs. Complete the "yes" or "no" lines for each drug listed, and if "yes", answer the remaining questions on the line.

	No, I Never Used	Yes, I Used	If yes, age at first use	When using, frequency of use (daily, weekly, etc.)	How long since last used?
Alcohol					
Marijuana/Hashish					
Cocaine					
Crack					
Crank					
Methamphetamine/ Speed					
Hallucinogens (LSD, Mushrooms, Mescaline, etc.)					
Other					

Please add any additional information about your drug use that you feel may be helpful as we work toward improving your emotional and mental health.

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these forms? Please tell me here; use the back of the paper if needed.

_____ _____

Client's Signature **Date**

Your Name: _____ ***Date:*** _____