UPLANDS COUNSELING ASSOCIATES (UCA)
ADULT HISTORY FORM

Legal Name: ____ DOB: ____________________

Preferred Name: ____ Preferred Pronouns: ___________________

What is your Best Hope about meeting with a clinician at UCA? ______________________________________

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____

Did someone refer you to UCA? ❒ Yes ❒ No If yes, who? _____________________________________

Have you worked with another mental health clinician in the past? ❒ Yes ❒ No If yes, who? _______________

____

What would be helpful for us to know about this experience? ____

____

____

Have you worked with a psychiatrist in the past or are you working with one now? ❒ Yes ❒ No If yes, who? _______

____

Please list your current medications including herbal remedies, vitamins, etc. the dosage and who is prescribing for you:

____

____

Are you aware of being diagnosed with any mental health conditions? ❒ Yes ❒ No If yes, what condition(s): ______

____

Have you ever been hospitalized for mental health treatment? If yes, how many times? ____________________

When and where was your most recent stay: ____

Are you aware of any members in the family with whom you grew up experiencing any mental health condition(s)?

❒ Yes ❒ No If yes, what condition(s): ____

____

____

Briefly describe your childhood and the family with whom you grew up: ______________________________

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____

Are there any concerns about the family with whom you grew up that you would like to talk with us about? ❒ Yes ❒ No

If yes, what would be helpful for us to know? ____

____

Have you experienced anything that you would consider abusive or traumatic in your life? ❒ Yes ❒ No If yes, what would be helpful for us to know? ____

____

Relationship Status: ❒ Single ❒ Partnered ❒ Married ❒ Divorced ❒ Legally Separated ❒ Widowed

Current living situation: ____

Do you feel safe in your current living situation**?** ❒ Yes ❒ No If no, what would be helpful for us to know? ________

____

____

Number and ages of children (if applicable): ____

____

____

Tell us about your current family: ____

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____

____

Current/Previous Occupation: ______________________________What makes/made you good at this? ____________

____

____

Student: ❒ Yes ❒ No If yes, what school do you attend? ____________________________________

Current Educational Level: ____

Military service: ❒ Yes ❒ No: If yes, what branch and when? ______________________________________

Do you have a spiritual affiliation? ❒ Yes ❒ No If yes, what is your affiliation? __________________________

Do you use caffeinated products and if so, what type and how often? ______________________________

Do you use tobacco products and if so, what type and how often? ________________________________

Do you drink alcohol or use drugs and if so, what type and how often? ____________________________

____

Are you currently involved in any legal problems? If yes, please explain: ___________________________

____

Do you exercise? If yes, what type of exercise do you do and how often? ___________________________

____

Do you have any current or chronic health conditions or allergies? If yes, please explain: __________________

____

Do you have a history of head injury or seizures? If yes, please explain: ____________________________

____

Who or what do you count on for support? ____

____

What has improved in your circumstance since you made the call to initiate services? ___________________

____

____

How did you contribute to this improvement? ____

____

What do you want us to know about your resilience? ____

____

Thank you for taking the time to share this information with us. We are looking forward to consulting with you.

_____________________________________ _____________________________

Signature Date