www.qcfamilycounseling.com
help@qcfamilycounseling.com
2485 Tech Drive, Bettendorf, IA. 52722 | Office: 563.355.1611 | Fax: 563.355.6617
303 18th Street, Rock Island, IL. 61201 | Office: 309.788.6374 | Fax:309.788.6375

Adult Contact Information

Client Name: ____________________________________ Date of Birth: _______________ Age: ___ Gender: ______________

Name & Gender if different with your insurance company: ____

Address: ____
Street City State Zip Code

Social Security Number: ______________________________

Insurance Information

Primary Health Insurance: ____

ID Number: ____ Group/Policy Number: _____________________

Subscriber Name: ____ Subscriber Date of Birth: ___________________

Relationship to Subscriber: ____ Subscriber Employer: _____________________

Subscriber Address: ____
Street City State Zip Code

Secondary Health Insurance (If Applicable): ____

ID Number: ____ Group/Policy Number: _____________________

Subscriber Name: ____ Subscriber Date of Birth: ___________________

Relationship to Subscriber: ____ Subscriber Employer: _____________________

Subscriber Address: ____
Street City State Zip Code

Contact Information

Phone Message OK?

Home: ____ ___Yes ___ No

Work: ____ ___Yes ___No

Cell: ____ ___Yes ___No

Email: ____ ___Yes ___No

How would you like to be reminded of your appointment? ___Call ___Text ___Email ___None

Name: ________________________________ D.O.B ______________ ID # ________________________________

Marital Status

○ Single	○ Divorced (_____ Years)	○ Living as Married (_____ Years)
○ Married (_____ Years)	○ Separated (_____ Years)	○ Widowed (_____ Years)

Spouse's/Partners Name: ____

If FCPC is unable to reach you, is it okay to contact your spouse/partner? ___Y ___N

Employment Status

Are you employed? ___Y ___N

Employer Name: ____

Emergency Contact Information

Name: ____

Address: ____

Street City State Zip Code

Phone Number: (_____) __________________________ Relationship to you: ___________________________________

Primary Care Physician

Current Physician: ____

Physician Address: ____

Street City State Zip Code

Physician Phone Number: (_____) ______________________ Physician Fax Number: (_____) ______________________

Referent

By whom were you referred? ____

Name: ______________________________ D.O.B _____________ ID # ______________________________

Presenting Problems and Concerns

Describe the problem that brought you here today: ____

____

Please check all the behaviors & symptoms that you consider problematic:

○ Distractibility	○ Lack of Motivation	○ Increased Libido
○ Hyperactivity	○ Withdrawal from People	○ Decreased Need for Sleep
○ Impulsivity	○ Anxiety/Worry	○ Increased Risky Behavior
○ Boredom	○ Panic Attacks	○ Wide mood Swings
○ Poor Memory/Confusion	○ Avoidance	○ Sleep Problems
○ Concentration/Forgetfulness	○ Fear Away from Home	○ Nightmares
○ Seasonal Mood Changes	○ Social Discomfort	○ Eating Problems
○ Sadness/Depressed Mood	○ Obsessive Thoughts	○ Gambling Problems
○ Unable to Enjoy Activities	○ Compulsive Behavior	○ Computer Addiction
○ Hopelessness	○ Aggression/Fights	○ Problems with Pornography
○ Thoughts of Death	○ Frequent Arguments	○ Parenting Problems
○ Self-Harm Behaviors	○ Increased Irritability/Anger	○ Sexual Problems
○ Crying Spells	○ Homicidal Thoughts	○ Relationship Problems
○ Loneliness	○ Flashbacks	○ Work/School Problems
○ Low Self Worth	○ Hearing Voices	○ Alcohol/Drug Use
○ Guilt/Shame	○ Visual Hallucinations	○ Recurring, Disturbing Memories
○ Fatigue	○ Suspicion/Paranoia	○ Viewing Pornography
○ Decreased Libido	○ Racing Thoughts	○ Other: _________________
○ Change in Appetite	○ Excessive Energy	

Are your problems affecting and of the following?

○ Handling Everyday Tasks	○ Self Esteem	○ Relationships	○ Hygiene
○ Work/School	○ Housing	○ Legal Matters	○ Finances
○ Recreational Activities	○ Sexual Activity	○ Health	○ Other: __________

Have you ever had feelings or thoughts that you did not want to live? If yes, please describe & answer the questions below: ____

- How often do you have these thoughts? ____
- When was the last time you had these thoughts of dying? ____
- Has anything happened recently to make you feel this way? _______________________________________
- On a scale of 1-10 (10 being the strongest) how strong is your desire to kill yourself currently? ______________
- Would anything make it better? ____
- Have you ever thought about how you would kill yourself? ____
- Is the method you would use readily available? ____
- Have you planned a time for this? ____
- Is there anything that would stop you from killing yourself? _______________________________________
- Do you feel hopeless and/or worthless? ____
- Have you ever tried to kill or harm yourself before? ____
- Do you have access to guns? ____ If yes, please explain: ____

Name: ________________________________ D.O.B ______________ ID # ________________________________

Have you recently been physically hurt or threatened by someone else? If yes, please describe: ____________________

____

Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe & answer the questions below: ____

- How often do you have these thoughts? ____
- On a scale of 1-10 (10 being the strongest) how strong is your desire to kill someone else currently? __________
- Have you ever thought about how you would kill someone else? ______________________________________
- Is the method you would use readily available? ____
- Have you planned for this? ____
- Do you feel hopeless and/or worthless? ____
- Have you ever tried to kill or har someone else before? ____
- Do you have access to guns? ____ If yes, please explain: ____

Please check if you have experienced and of the following types of trauma or loss.

○ Emotional Abuse	○ Violence in the Home	○ Homelessness
○ Sexual Abuse	○ Crime Victim	○ Loss of a Loved One
○ Physical Abuse	○ Parent Illness	○ Financial Problem
○ Parent Substance Abuse	○ Place a Child for Adoption	○ Miscarriage/Stillborn
○ Teen Pregnancy	○ Lived in a Foster Home	○ Other: __________________
○ Neglect	○ Multiple Family Homes	

Please note if any family members have experienced any of the following mental health problems.

Family Mental Health History	Who?
ADHD	
Experienced Sexual Abuse	
Depression	
Bipolar Disorder	
Made Suicide Attempt	
Anxiety Problems	
Panic Attacks	
Obsessive-Compulsive Disorder	
Anger Problem/Abusive Disorder	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Autism	
Self-Harm Behavior	
Other	

Name: ________________________________ D.O.B ______________ ID # ________________________________

Family Background and Childhood History

Were you adopted? ___Yes ___No

If yes, what age? _______________

Where did you grow up? ____

What was your father's occupation? ____

What was your mother's occupation? ____

Did your parents' divorce? ___Yes ___No

If yes, how old were you? ____

Who did you live with? ____

Describe your father and your relationship with him: ____

____

Describe your mother and your relationship with her: ____

____

How old were you when you left home? ____________________

Has anyone in your immediate family died? ___Yes ___No If yes, who and when? ________________________________

____

Relationship History and Current Family

Are you currently:

- Married
- Partnered
- Divorced
- Single
- Widowed

How long? __________________________________

If not married, are you currently in a relationship? ___Y ___N If yes, how long? _________________________

Are you sexually active? ___Y ___N

How would you identify your sexual orientation? ____

What is your spouse or significant other's occupation? ____

Describe your relationship with your spouse or significant other: ____

____

Have you had any prior marriages? ___Y ___N If so, how many? __________ For how long? __________

Do you have children? ___Y ___N If yes, list ages and gender: ______________________

Describe your relationship with your children: ____

____

List everyone who currently lives with you: ____

Name: _________________________________ D.O.B ______________ ID # _________________________________

Previous Mental Health Treatment

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (Mental Health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-Help/Support Groups			

Substance Use History

		Yes	No	Frequency	Amount
Tobacco	Current use (last 6 months)				
	Past Use				
Caffeine	Current use (last 6 months)				
	Past Use				
Alcohol	Current use (last 6 months)				
	Past Use				
Marijuana	Current use (last 6 months)				
	Past Use				
Cocaine/Crack	Current use (last 6 months)				
	Past Use				
Ecstasy	Current use (last 6 months)				
	Past Use				
Heroin	Current use (last 6 months)				
	Past Use				
Inhalants	Current use (last 6 months)				
	Past Use				
Methamphetamines	Current use (last 6 months)				
	Past Use				
Pain Killers	Current use (last 6 months)				
	Past Use				
PCP/LSD	Current use (last 6 months)				
	Past Use				
Steroids	Current use (last 6 months)				
	Past Use				
Tranquilizers	Current use (last 6 months)				
	Past Use				

Have you had withdrawal symptoms when trying to stop using substances ___Y ___N

If yes, please describe: ____

Have you gambled in the past 6 months? ___Y ___N If yes, let us know the following:

Have you ever felt the need to bet more and more money? ___Y ___N

Have you ever had to lie to people important to you about how much you gambled? ___Y ___N

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? ___Y ___N

If yes, please describe: ____

Name: ________________________________ D.O.B ______________ ID # ________________________________

____

Medical Information

Date of last physical exam: _______________________________

Personal and Family Medical History:

	Self	Family Member	
Allergies			
Chronic Pain			
Dizziness/Fainting			
High Fevers			
Sexually Transmitted Disease			
Obesity			
Asthma/Respiratory Problems			
Surgery			
Meningitis			
Diabetes			
Abortion			
Headaches			
Serious Accident			
Seizures			
Hearing Problems			
Sleep Disorder			
Stomach Aches			
Head Injury/Trauma			
Vision Problems			
Miscarriage			
Thyroid Disease			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Stomach or Intestinal Problems			
Cancer (Type)			
Fibromyalgia			
Heart Disease			
Chronic Pain			
High Cholesterol			
High Blood Pressure			
Liver Problems			
Other: ________________			

Please list any current health concerns: ____

Name: _________________________________ D.O.B ______________ ID # _________________________________

____

Past medical problems, surgeries, or non-psychiatric hospitalization: ____

____

Add additional personal or family history: ____

____

Current prescription medications: ___None

Medication	Dosage	Date First Prescribed	Prescribed By	Taken For

Current over-the-counter medications or supplements? (Including vitamins, herbal remedies, etc.):

____

____

____

Allergies and/or adverse reactions to medications: ____None

____

Interpersonal/Social/Cultural Information

Please describe your social support network (check all that apply)

- ○ Family
- ○ Neighbors
- ○ Support/Self-Help Group
- ○ Friends
- ○ Students
- ○ Community Group
- ○ Co-Workers
- ○ Religious/Spiritual Center

To which cultural or ethnic group do you belong? ____

If you are experiencing any difficulties due to cultural or ethnic issues, please describe: ___________________________

____

How important are spiritual matters to you? ___ Not at All ___Little ___ Somewhat ___Very Much

Would you like spiritual/religious beliefs to be incorporated into your counseling? ___Y ___N

Please describe your strengths, skills, and talents: ____

____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): ______________________________

____

Name: _______________________________ D.O.B _____________ ID # _______________________________

Miscellaneous Information

Employment:

Employer: _______________________________________ Position: ____

Length of time at this position: _______________________ Job Duties: ______________________________________

Stress Level of this position: ___Low ___Medium ___High

Other Jobs you have held: ____

Education:

Are you currently attending school? ___Y ___N

	Yes	No	Year Graduated	Major of Study	School Attended
High School Graduate					
GED					
Associate degree					
Undergraduate Degree					
Graduate Degree					

Military Service:

Have you been or are you currently in the military? ___Y ___N

If yes: Branch______________________ Date of Discharge ___________________ Type of Discharge________________

Rank _______________________ Were you in combat? ___Y ___N

Legal:

Have you ever been arrested? ___Y ___N

Do you have any pending legal problems? ___Y ___N

Have you ever been convicted of a misdemeanor or felony? ___Y ___N If yes, please explain: _____________________

____

Are you currently involved in any divorce or child custody proceedings? ___Y ___N If yes, please explain: ___________

____

Client Signature: ____ Date: _____________________