

## Adult Background Information

### SMU Center for Family Counseling

5228 Tennyson Parkway\*Plano, TX 75024

972-473-3456 (phone)\* 972-473-3490 (fax)

www.smu.edu/familycounseling

*Welcome to the Center for Family Counseling at SMU! Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your intake counselor will discuss your responses with you after he/she has reviewed the form.*

Name: \_\_\_\_\_ First Visit Date: \_\_\_\_\_

Last                      First                      MI

Gender Identification: Male\_\_ Female\_\_ Other: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation: \_\_\_\_\_ Length of Time at this Job: \_\_\_\_\_

*Ethnicity:*

African American\_\_      Bi-racial\_\_                      Hispanic/Latino\_\_  
Asian\_\_                      Caucasian\_\_                      Native American\_\_                      Other \_\_\_\_\_

Primary language: English \_\_ Spanish \_\_ Other \_\_

### **CONTACT INFORMATION:**

Cell Phone: \_\_\_\_\_ (May call? Yes No May Leave Message? Yes No)

Home Phone: \_\_\_\_\_ (May call? Yes No May Leave Message? Yes No)

Work Phone: \_\_\_\_\_ (May call? Yes No May Leave Message? Yes No)

Best Time and Place to call: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street                                      City                                      State                                      Zip

May we correspond with you via mail at the above address: Yes No

*In case of emergency, I authorize the Center for Family Counseling to contact:*

\_\_\_\_\_  
Name: Last, First

\_\_\_\_\_  
Relationship

Person responsible for financial arrangements with our clinic: \_\_\_\_\_

Name: Last, First

Who referred you to our Center? (Please be specific): \_\_\_\_\_

May we contact this referral source to thank them for the referral: Yes No



**CURRENT CONCERNS**

**General reason(s) for seeking counseling services at this time:** \_\_\_\_\_

\_\_\_\_\_

\* Circle all items that you see as ongoing struggles in your life that you would like to work on in counseling

Issues Related to Abuse

- Current or past physical abuse
- Current or past sexual abuse
- Current or past emotional abuse
- Current or past neglect
- History of abandonment/rejection
- Suspected sexual abuse
- History of family domestic violence

Career/Academic Issues

- Colleague/Cohort problems
- Harassment issues
- General work performance issues
- Failing grades
- Chronic stress
- Career dissatisfaction
- General problems at work/school

Mood-Related Concerns

- Disturbing memories
- Difficulty going to sleep/Staying asleep
- Nightmares/Night terrors
- Suicidal thinking or talking
- Suicidal attempting
- Sadness/Depression
- Feelings of guilt and shame
- Excessive worrying or fear

Family Relationship Concerns

- Difficulty adjusting to family changes
- Parenting/Discipline concerns
- Parent-child relationship problems
- Divorce
- Separation
- Religious/Spiritual Concerns
- Estranged relationships
- Constant fighting

Behavioral/Conduct Issues

- Aggression toward others
- Drug/alcohol use
- Hyperactive/Impulsivity
- Excessive computer use
- Lying
- Betraying relationships
- Engaging in high risk-taking behaviors
- Fire-setting
- Other unusual behaviors (please specify) \_\_\_\_\_

Other Behavioral Concerns

- Sexual identity questioning
- Sexual issues in general
- Appetite/Eating concerns
- Sleep problems
- Time management concerns
- Inattentive
- Lonely
- Bored with Life

***\*Please place a star by the most significant issue***

*Please briefly discuss the above behaviors you have concerns about:* \_\_\_\_\_

\_\_\_\_\_

*When did you first become concerned about the main/most significant issue?* \_\_\_\_\_

*Why, at this point, have you decided to pursue counseling for the concern(s) above?* \_\_\_\_\_

\_\_\_\_\_

*Other treatment you have received to address any of the concerns indicated above:* None \_\_\_\_\_

Couples Counseling \_\_\_\_\_

Group counseling \_\_\_\_\_

Individual counseling \_\_\_\_\_

Family counseling \_\_\_\_\_

Hospitalization \_\_\_\_\_

Other \_\_\_\_\_

Are you currently in counseling elsewhere? Yes No

(If yes, we require written confirmation of the counselor's consent for treatment by the center)

Are other family members receiving services at this clinic? Yes No

(Name/Dates of service) \_\_\_\_\_

Are you seeking services because you are a victim of a crime? Yes No

If yes, did it result in legal action? Yes No

Are you currently on probation? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No

(If yes, we will need your permission in order to communicate with that individual or agency. We reserve the right to postpone services until prior treatment providers are contacted.)

Previous Mental Health Professional/Agency \_\_\_\_\_

Phone \_\_\_\_\_ Dates of Service \_\_\_\_\_ (beginning - ending)  
Name Address

Have you ever been hospitalized for mental health concerns: Yes No

If yes please explain: \_\_\_\_\_

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married \_\_\_\_\_

Married 1 \_\_\_\_\_ Separated 1 \_\_\_\_\_ Divorced 1 \_\_\_\_\_ Widowed 1 \_\_\_\_\_

Married 2 \_\_\_\_\_ Separated 2 \_\_\_\_\_ Divorced 2 \_\_\_\_\_ Widowed 2 \_\_\_\_\_

Married 3 \_\_\_\_\_ Separated 3 \_\_\_\_\_ Divorced 3 \_\_\_\_\_ Widowed 3 \_\_\_\_\_

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly  
1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

Are you currently involved in a custody dispute: Yes No (If yes, explain) \_\_\_\_\_

**Current living arrangements:**

Family of origin \_\_\_\_\_

Relatives \_\_\_\_\_

Single \_\_\_\_\_

Married \_\_\_\_\_

Partner \_\_\_\_\_

Roommate(s) \_\_\_\_\_

Single parent w/children \_\_\_\_\_

Partner w/ children \_\_\_\_\_

Married w/children \_\_\_\_\_

Significant other \_\_\_\_\_

Significant other w/ children \_\_\_\_\_ Other \_\_\_\_\_

**Present Family**

If married with children, list your family, beginning with the oldest member and include yourself.

Name Age Gender Relationship to you (include step, half, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family of Origin Primary Household** (Family in which you resided the majority of your life)

List your family members, by household, beginning with the oldest member (include parents and self):

Name Age Gender Relationship to you (include step, half, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Obsessive/ \_\_\_\_\_  
 Compulsive \_\_\_\_\_

Addictions \_\_\_\_\_

Convulsions \_\_\_\_\_

Other \_\_\_\_\_

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If you have been diagnosed, who gave the diagnosis?

Counselor/Psychologist\_\_\_ Family Physician\_\_\_ Psychiatrist\_\_\_ School\_\_\_ Other\_\_\_  
 Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

List other medication you are currently taking:

Med. \_\_\_\_\_ Dosage \_\_\_\_\_  
 Med. \_\_\_\_\_ Dosage \_\_\_\_\_  
 Med. \_\_\_\_\_ Dosage \_\_\_\_\_

Health/Physical Problems (check all that apply):

Asthma___	Disability___	Nervous stomach___
Bedwetting___	Dizziness___	Neurological problems/Exam___
Bone/Joint/Muscle___	Headache (kind)___	PMS___
Chest pain___	Heart palpitations___	Serious overeating/Under eating___
Chronic illness___	Hospitalization___	Shortness of breath without exertion___
Developmental delay(s)___	Major accident___	Sleep problem___
Diarrhea___	Major illness___	Surgeries___
		Other _____

**FAMILY HISTORY/EXPERIENCES**

(For each of the following items that apply, write in your approximate age at the time it occurred):

Raised by:

Adoptive parent(s)___	Institution___	Relatives___
Foster parents___	Natural parents___	Single natural parent___
Grandparents___	Natural and step-parent___	Other _____

Stressors in the Family:

Chronic illness of family member\_\_\_ Death of significant person\_\_\_ Domestic Violence\_\_\_  
 Family member absent (explain) \_\_\_\_\_  
 Family member disability/Major accident/illness\_\_\_  
 Family member emotional problems (explain) \_\_\_\_\_  
 Family member suicide (explain) \_\_\_\_\_  
 Financial problems\_\_\_ Moved a lot\_\_\_ Parents arguing frequently\_\_\_ Parents divorced\_\_\_  
 Other \_\_\_\_\_

History of learning, emotional, behavioral problems: Yes No

(If yes, please explain) \_\_\_\_\_

History of alcohol/drug/substance abuse: Yes No

(If yes, please explain) \_\_\_\_\_

History of family violence: Yes No

(If yes, please explain) \_\_\_\_\_

History of criminal activity: Yes No

(If yes, please explain) \_\_\_\_\_

History of Protective orders: Yes No

(If yes, please explain) \_\_\_\_\_

Abused (check all that apply): Physically\_\_\_ Emotionally\_\_\_ Sexually\_\_\_

Neglected (check all that apply): Physically\_\_\_ Emotionally\_\_\_

*Dissociative Symptoms (check all that apply):*

Amnesia of large parts of childhood after age 5 \_\_\_  
Memories suddenly flashback \_\_\_  
Things appear but you don't know origin \_\_\_

Things of yours that are missing \_\_\_  
Trance-like episodes/Lost track of time \_\_\_  
Walk in sleep \_\_\_

*Trauma/Stressor (check all that apply):*

Child separated from parent (how long and when) \_\_\_\_\_  
Death of a pet \_\_\_                      Death of a significant person \_\_\_                      Incarcerated family member \_\_\_  
Medical \_\_\_                                  Natural disaster \_\_\_                                  Sexual assault \_\_\_  
Victim of trauma (unusual, terrifying experience) \_\_\_                      Other \_\_\_\_\_

*Interpersonal Problems (check all that apply):*

Aggressive behavior (explain) \_\_\_\_\_  
Bullied \_\_\_    Taken advantage of \_\_\_  
Frequent arguments \_\_\_                              Temper outbursts \_\_\_  
Loner \_\_\_    Other \_\_\_\_\_

*Specific to Adulthood (check all that apply):*

Abortion \_\_\_  
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment, etc.) \_\_\_  
Parenting/Discipline problems \_\_\_                      Placing child for adoption \_\_\_  
Sexual problem (explain) \_\_\_\_\_

*Family of Origin Atmosphere (circle the number that best describes how you viewed your family while you were growing up):*

Very lenient      1      2      3      4      5      Very strict  
Very non-religious 1      2      3      4      5      Very religious  
Chaotic              1      2      3      4      5      Highly structured  
Few expectations 1      2      3      4      5      High expectations  
Inconsistent      1      2      3      4      5      Consistent

*Family of Origin Support System (such as church, friends, relatives, school)*

Hardly any support 1      2      3      4      5      Considerable support

*Family Atmosphere (circle the number that best describes how you view your current family, if applicable):*

Very lenient      1      2      3      4      5      Very strict  
Very non-religious 1      2      3      4      5      Very religious  
Chaotic              1      2      3      4      5      Highly structured  
Few expectations 1      2      3      4      5      High expectations  
Inconsistent      1      2      3      4      5      Consistent

*Family Support System (such as church, friends, relatives, school)*

Hardly any support 1      2      3      4      5      Considerable support

*Your current use of computer and television (circle the number of hours that best describes use):*

Computer (circle approximate hours spent each week)

0-2    3-5    6-8    9-11    12+

What do you enjoy doing the most on the computer: \_\_\_\_\_

TV (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

What do you watch on TV: \_\_\_\_\_

I agree that the above information is accurate to the best of my ability. I also understand that if I have any questions regarding the above questions, I can ask my screening/intake counselor at any time. I also understand that completing this intake does not guarantee that counseling services will be rendered at this Center.

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Client/Guardian

Date

2/16/2010