1303 Fifth St., Suite 202
Coralville, IA 52241
phone 319.358.6520
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HOPE SPRINGS
Behavioral Consultants

ADULT INFORMATION FORM

Name: Last _____ First _____ MI _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) - _____ Work: _____

Cell: (_____) - _____ Is it okay to call at work? _____

Email: (**please print clearly**) _____

Birthdate: _____ Age: _____ Education: _____

Employer: _____ Occupation: _____

Single: _____ Married: _____ Other: _____

Spouse/Partner Name: _____ DOB: _____ Age: _____

Spouse/Partner Employer: _____

Emergency Contact Person: _____ Phone: _____

Emergency Contact relationship to you: _____

Children's Names and Ages: _____

_____

Personal Physician: _____ Psychiatrist: _____

INSURANCE INFORMATION

(Skip this section if no insurance is being filed)

Primary Health Benefit Plan: _____

Insurance Company Claims Address: _____

City: _____ State: _____ Zip: _____

In whose name is your insurance plan: _____

Member's DOB: _____ Member's Employer: _____

Insurance Plan ID #: _____ Group Number: _____

Is pre-certification required? _____

HEALTH HISTORY

Have you ever had any of the following:

Allergies/Asthma	Childhood_____	Currently_____
Heart Problems	Childhood_____	Currently_____
Epilepsy or Seizures	Childhood_____	Currently_____
High blood pressure	Childhood_____	Currently_____
Serious head injury	Childhood_____	Currently_____
Surgery	Childhood_____	Currently_____
Migraines	Childhood_____	Currently_____
Thyroid condition	Childhood_____	Currently_____
Hearing Problems	Childhood_____	Currently_____
Diabetes	Childhood_____	Currently_____

Any other serious medical problems? Explain: _____

_____

Current Medications and Doses: _____

_____

_____

Who prescribes: Physician: _____ Clinic: _____

FAMILY HISTORY

Parents' marital status: _____ Divorced ____Widowed _____Married

Mother's Occupation: _____ Father's Occupation: _____

Siblings' Names and Ages: _____

_____

Describe what growing up in your family was like: _____
_____
_____

Did you experience physical, verbal, sexual or emotional abuse as a child or teen? If yes, please explain: _____
_____
_____

Please list psychiatric or medical conditions of your biological relatives including your siblings, parents, maternal and paternal grandparents. Please note conditions such as depression, anxiety, ADHD, bipolar, substance abuse, or other medical or psychiatric conditions: _____
_____
_____
_____

PAST PSYCHIATRIC HISTORY

Have you previously been diagnosed with ADHD? ___ Yes _____ No

Have you ever seen a counselor or psychiatrist before? _____Yes _____ No

Have you ever been diagnosed with depression? _____ Yes _____ No

Have you ever made any suicide attempts? _____ Yes _____ No

Have you ever had problems with anxiety? _____ Yes _____ No

Have you ever been treated for alcohol/drug problems? _____ Yes _____ No

How much alcohol do you drink per week? _____

Are you presently using any other drugs recreationally? _____ marijuana _____ heroin

_____ tranquilizers _____ amphetamines _____ barbiturates _____ cocaine _____ opiates

OTHER CONCERNS

Prolonged periods of sadness/depression	_____ past	_____ present
Excessive anxiety	_____ past	_____ present
Panic or anxiety attacks	_____ past	_____ present
Compulsive habits or rituals	_____ past	_____ present
Significant appetite changes	_____ past	_____ present
Significant changes to sleep pattern	_____ past	_____ present
Manic episodes	_____ past	_____ present

Other symptoms of mental distress: explain: _____
_____
_____
_____