MARIA DROSTE
COUNSELING SERVICES
BRINGING HOPE TO LIFE

Adult History Form

Name	Last		First
	Middle		Preferred/nickname
Address	Street		
	City	State	Zip
Telephone	Cell	Home	Work

If you are here for couples counseling with your partner, please provide their information below:

Partner's name	Last		First
	Middle		Preferred/nickname
Partner's address Same as above: ☐	Street		
	City	State	Zip
Partner's phone	Cell	Home	Work

Emergency contact

Name	Relationship to you	Phone

SIGNATURE: _____ DATE: _____

PLEASE READ: Unless otherwise noted, your signature indicates that you agree with the following statement: Maria Droste Counseling Services (MDCS) uses your information for our internal statistics to help shape our future programming. Please understand that any data used will remain **completely anonymous**. We will never share you or your child's information with any third parties unless requested by you and in compliance with our policies. We do share aggregate summaries with others for the purposes of outreach and improving our services, which does not include your individual responses to any questions or any identifiable information about you. Please speak with your therapist if you have any questions or concerns about this statement.

For clinician use only:		
Clinician name:	Client ID (assigned on intake):	☐ Client denied use of information for internal data collection.

GENERAL INFORMATION

Race: *(check all that apply)*	☐ American Indian/Alaskan Native ☐ Middle Eastern/North African ☐ Asian/Asian American ☐ Native Hawaiian/Pacific Islander ☐ Black/African/African American ☐ White ☐ _____		
Ethnicity:	☐ Hispanic/Latino(a) ☐ Not Hispanic/Latino(a) ☐ _____		
Language(s):			
Gender:	☐ Male ☐ Female ☐ _____	Are you a female head of household:	☐ Yes ☐ No
Pronouns:	☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ _____		
Marital status:	☐ Single ☐ In a significant relationship ☐ Living with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Veteran status:	☐ Yes, I am a veteran Branch: _____ Years of Service: _____ to _____ ☐ Not a veteran
Education: *(check all that apply)*	☐ High school ☐ Technical training ☐ Associate's degree ☐ Bachelor's degree ☐ Master's degree ☐ Doctoral degree ☐ None of the above	Employment status: *(check all that apply)*	☐ Full-time ☐ Part-time ☐ Self-employed ☐ Student ☐ Homemaker ☐ Retired ☐ Disabled ☐ Unemployed
Annual household income:	☐ Less than $25,000 ☐ $25,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000 or more	Employer: *(We will not share any of your information with your employer.)*	
		Occupation/ Trade:	
Please list all current members of your household and their ages:	☐ I live alone.		

Are you currently on probation or parole?	☐ Yes	☐ No
Do you currently have DCF involvement?	☐ Yes	☐ No
Are the services you are seeking today mandated by the courts?	☐ Yes	☐ No
Are you under pressure by friends or family to be here today?	☐ Yes	☐ No

HEALTHCARE PROVIDER INFORMATION

What type of health insurance coverage do you have?	☐ Private ☐ State ☐ Medicare	☐ Medicaid ☐ Employee Assistance (EAP)	☐ Military ☐ I do not have health insurance
Do you see a psychiatrist/physician?	☐ Yes ☐ No *If yes, please provide details.*	*Name* *Phone* *Address*	
Do you receive pension or compensation for a psychiatric disability?	☐ Yes ☐ No *If yes, please provide details.*	*Psychiatric disorder(s)*	
Have you ever had any previous mental health counseling?	☐ Yes ☐ No *If yes, please provide details.*	*Therapist/agency, year began, year ended*	
Have you ever been hospitalized for mental health reasons?	☐ Yes ☐ No *If yes, please provide details.*	*Date(s), description*	
Have you ever been given a mental health diagnosis?	☐ Yes ☐ No *If yes, please provide details.*	*Diagnosis(es)*	

MEDICAL INFORMATION

When did you last have a medical checkup (if unknown, estimate)?			
Do you have allergies or allergic reaction to medication(s)?	☐ Yes ☐ No *If yes, please provide details.*	*Allergies*	
Have you ever had any of the following problems?	☐ Seizure ☐ Head injury ☐ High blood pressure ☐ Heart trouble	☐ Kidney problems ☐ Diabetes ☐ Asthma ☐ Thyroid problems	☐ Liver problems ☐ High cholesterol ☐ Chronic migraines ☐ _____ ☐ None of the above
Have you ever had any surgery or medical hospitalizations?	☐ Yes ☐ No *If yes, please provide details.*	*Date(s), description*	

Medical Information continued on page 4.

Medical Information continued from page 3.

Do you have any chronic medical conditions that interfere with your life?	☐ Yes ☐ No *If yes, please provide details.*	How troubled or bothered have you been by these conditions in the past 30 days? *(circle)* ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Not at all Extremely
Please list any prescription medications you are currently taking:	*Medication, dose, frequency*	☐ I do not take any medication.

ALCOHOL AND CHEMICAL USE

Substance	Currently use?	Previously used?	Type/Amount/Frequency	How long? (years)	If stopped, when? (yr)
Caffeine *(ex:coffee, tea, soda)*	☐ Yes ☐ No	☐ Yes ☐ No			
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No			
Alcohol *(ex: beer, wine, liquor)*	☐ Yes ☐ No	☐ Yes ☐ No			
Marijuana	☐ Yes ☐ No	☐ Yes ☐ No			
Opioids *(ex: heroin)*	☐ Yes ☐ No	☐ Yes ☐ No			
Stimulants *(ex: cocaine, meth)*	☐ Yes ☐ No	☐ Yes ☐ No			
Prescription pills *(not as prescribed)*	☐ Yes ☐ No	☐ Yes ☐ No			
Other	☐ Yes ☐ No	☐ Yes ☐ No			

Alcohol and Chemical Use continued on page 5.

Alcohol and Chemical Use continued from page 4.

1. Are you seriously considering addressing your alcohol and/or drug use within the next six months? ☐ Yes ☐ No
2. Are you now actively remaining abstinent from your use of alcohol and/or drugs? ☐ Yes ☐ No
3. Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
4. Have you ever had people annoy you by criticizing your drinking or drug use? ☐ Yes ☐ No
5. Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
6. Have you ever had a drink or used drugs as an eye opener first thing in the morning to steady your nerves, to get rid of a hangover, or to get the day started? ☐ Yes ☐ No

FAMILY HISTORY

1. Are there any substance use issues in your family or with your significant other? ☐ Yes ☐ No

   If yes, please describe:

2. To your knowledge, does anyone in your family have a history of mental illness? ☐ Yes ☐ No

   If yes, please describe:

SYMPTOMS

To what degree have you felt distressed over the past two weeks?	☐ 0 Not at all	☐ 1	☐ 2	☐ 3	☐ 4 Extremely
To what degree are you feeling distressed upon entering counseling today?	☐ 0 Not at all	☐ 1	☐ 2	☐ 3	☐ 4 Extremely
Sometimes things happen to people that are extremely upsetting (ex: being in a life threatening situation like a major disaster, serious car accident or fire; being physically or sexually assaulted; seeing another person go through a trauma such as the ones listed above). At any time during your life, have any of these kinds of things happened to you?	☐ Yes	☐ No			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure- Adult

Instructions: The questions below ask about things that might have bothered you. For each question, select the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** None at all	**Slight** Rare, less than one or two days	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I	1. Little interest or pleasure in doing things?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	2. Feeling down, depressed, or hopeless?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
II	3. Feeling more irritated, grouchy, or angry than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
III	4. Sleeping less than usual, but still having a lot of energy?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	5. Starting lots more projects than usual or doing more risky things than usual?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IV	6. Feeling nervous, anxious, frightened, worried, or on edge?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	7. Feeling panic or being frightened?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	8. Avoiding situations that make you anxious?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
V	9. Unexplained aches and pains (e.g. head, back, joints, abdomen, legs)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	10. Feeling that your illnesses are not being taken seriously enough?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VI	11. Thoughts of actually hurting yourself?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VII	12. Hearing things other people couldn't hear, such as voices even when no one was around?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
VIII	14. Problems with sleep that affected your sleep quality overall?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
IX	15. Problems with memory (e.g. learning new information) or with location (e.g. finding your way home)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
X	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XI	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XII	19. Not knowing who you really are or what you want out of life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	20. Not feeling close to other people or enjoying your relationships with them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
XIII	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

MARIA DROSTE QUALITY OF LIFE SURVEY- ADULT

Please check the box which best describes how well you are doing on your job:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not working
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing in your marital/significant other relationship:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing in your family relationships:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing with friendships and socializing:

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes how well you are doing taking care of yourself (i.e., keeping up with household chores, managing medical care, being physically active, doing activities or hobbies):

No problems	Mild problems	Moderate problems	Serious problems	Cannot function	Not applicable
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ n/a

Please check the box which best describes your current physical health:

Excellent	Good	Fair	Poor	Very poor
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Please check the box which best describes your general happiness and wellbeing:

Excellent	Good	Fair	Poor	Very poor
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4