

**Denise Candidi, LPC, LLC**

2605 Egypt Road  
Suite 201

Trooper, PA 19403

Phone: 484-849-1482

www.denisecandidi.com

Fax: 610-279-2375

**ADULT INFORMATION FORM**

Name \_\_\_\_\_ Date of 1<sup>st</sup> Appointment \_\_\_\_\_ Therapist \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

**MEDICAL HISTORY**

Name of Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: \_\_\_\_\_

Date of last medical evaluation: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Current medications being taken:

- 1) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 2) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 3) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_
- 4) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? \_\_\_\_\_

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? \_\_\_\_\_

Describe any important medical history, chronic ailments, or other health problems you experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: \_\_\_\_\_

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: \_\_\_\_\_

### SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain: \_\_\_\_\_

What was the last year of school you completed? \_\_\_\_\_ If you did not complete high school, please explain: \_\_\_\_\_

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) \_\_\_\_\_ Year(s) \_\_\_\_\_  
(2) School(s) \_\_\_\_\_ Year(s) \_\_\_\_\_  
(3) School(s) \_\_\_\_\_ Year(s) \_\_\_\_\_

How would you describe your current support network? (friends, relatives, etc.): \_\_\_\_\_

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom? \_\_\_\_\_

Where do your parents live? Mother \_\_\_\_\_  
Father \_\_\_\_\_

Describe your relationship with your mother while growing up: \_\_\_\_\_

Currently: \_\_\_\_\_

Describe your relationship with your father while growing up: \_\_\_\_\_

Currently: \_\_\_\_\_

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: \_\_\_\_\_  
\_\_\_\_\_

Sexual/physical/emotional abuse: \_\_\_\_\_  
\_\_\_\_\_

### MARITAL HISTORY

Marital status:  Single/never married  Married  Separated  Divorced  Widowed  Living w/someone  
If currently married, when were you married? \_\_\_\_\_ If living w/someone, how long? \_\_\_\_\_

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

sad  anxious  depressed  frightened  guilty  angry  ashamed  aggressive  resentful  
 worthless  tearful  irritable  confused  extreme ups/downs  jealous  hopeless  helpless

Describe any other feelings you have had: \_\_\_\_\_  
\_\_\_\_\_

What activities or hobbies do you participate in? \_\_\_\_\_  
\_\_\_\_\_

Do you participate in regular exercise? (Circle One) YES NO Describe: \_\_\_\_\_

Describe your current working environment: \_\_\_\_\_  
\_\_\_\_\_

Have you had any change in sleeping habits? (Circle One) YES NO Describe: \_\_\_\_\_  
\_\_\_\_\_

Have you had any change in eating habits? (Circle One) YES NO Describe: \_\_\_\_\_  
\_\_\_\_\_

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO  
If so, please give a brief description with dates: \_\_\_\_\_

Have you ever **considered suicide** in the **past**? (Circle One) YES NO  
If so, please give a brief description with dates: \_\_\_\_\_

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO  
If so, please give a brief description with dates: \_\_\_\_\_

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO  
If yes, please explain: \_\_\_\_\_

Have you ever **considered homicide** in the **past**? (Circle One) YES NO  
If yes, please explain: \_\_\_\_\_

**LEVEL OF FUNCTIONING**

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): \_\_\_\_\_

**THOUGHTS:** Please check any of the following that apply to you:

\_\_\_\_ I sometimes hear voices even though no one nearby is talking to me.

\_\_\_\_ I sometimes feel that forces outside of me control me.

\_\_\_\_ I sometimes feel that other people control my thoughts.

\_\_\_\_ I sometimes have the same thought over and over and cannot control it.

\_\_\_\_ I sometimes feel that someone is out to hurt me or do something against me.

\_\_\_\_ I am sometimes unable to control my behavior. Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list your therapy goals:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

THANK YOU!