James M. Mours, L.L.C.

Adult - Client Information & History

Today's date: __________________

Note: If you have been a patient here before, please fill in only the information that has changed.

Identifying Information

Your name: ____________________________________ Date of birth: _____/_____/______ Age: ______

Nicknames or aliases: _________________________________ Social Security #: ______/_____/________

Home street address: ____ Apt.: _____________

City: ____ State: _____________ Zip: ____________

Home/evening phone: ________________________________ e-mail: ________________________________

Calls or e-mail will be discreet, but please indicate any restrictions: _________________________________

Referral: Who referred you here? How did you learn about Dr. Mours?

Name: ____ Phone: ___________________________

Address: ____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No

How did this person explain how I might be of help to you? ____

____

Family Information

Where were you born and raised? ____

Please list your immediate family members growing up.

Parents Name & Relationship:	Siblings Name & Relationship:
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

Did any members of your immediate family have mental health issues? ❑ Yes ❑ No

If yes, who and what issue? ____

____

Marital Status: ❑ Single ❑ Divorced: _____ yrs ❑Living together _____ yrs ❑ Married _____ yrs

❑ Separated ______ yrs ❑ Widowed _____ yrs

If single, are you currently in a relationship? ❑ Yes ❑ No How many months? ______________

Number of intimate relationships with the past: Year ________, Five years ________

Please list your current family, plus any ex-spouses or children from another relationship:
Name *Occupation/Grade* *Age* *Relationship*

____
____
____
____
____
____

Religious and racial/ethnic information

Current religious denomination/affiliation: ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist

Other (specify): ____

Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? ____

Which (if any) church, synagogue, temple, or meeting are you involved with? ____________________

Ethnicity/national origin: ___________________________ Race: ____________________ or other similar way you identify yourself and consider important: _______________________________

Educational History

Highest Grade Completed: ___________

High School: ______________________________ City & State: __________________________

College/other: _____________________________ City & State: __________________________

College/other: _____________________________ City & State: __________________________

Degrees/Awards: ____

Did you have any special educational needs? ❑ Yes ❑ No

If yes, what? _________________________

Did you repeat any grades? ❑ Yes ❑ No

If yes, what grade? __________

Other significant educational history: (expelled, suspended, assaulted, pregnancy, etc.?) ____________

____

Military History

Have you previously or are you currently serving in the military? ❑ Yes ❑ No

Branch: __________ Date of service: ___________________ Currently in the Reserves ❑ Yes ❑ No

Highest Rank: ______ MOS: ___________________________ Type of Discharge: _____________

Did you experiences combat? ❑ Yes ❑ No

If yes, where & when? ____

Significant military awards/medals: ____

Your current employer

Employer: ____________________________________ Address: ___________________________________

Work phone: _______________________ or other means of communication _________________________

Calls would be discreet, but please indicate any restrictions:

____

How long have you worked for this employer? ______________

Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: ____ Phone: _______________________

Address: ____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Medical History

Have you experienced any of the following medical conditions during your lifetime?

❑ Allergies ❑ Asthma ❑ Headaches ❑ Chronic pain ❑ Stomach aches ❑ Head injury

❑ Serious accident ❑ Dizziness/fainting ❑ Seizures ❑ Meningitis ❑ Vision problems ❑Diabetes

❑ Hearing problems ❑ Miscarriage ❑ Abortion ❑ Sexually transmitted disease ❑ Sleep disorder

Please list major illnesses, injuries, surgeries and hospitalizations:________________________________

____

____

Please list any CURRENT health concerns: ____

____

____

Please list all medications you are currently taking:

Medication *Frequency* *Amount* *For What ?*

____

____

____

____

____

Have you ever been prescribed medication for mental health issues? ❑ Yes ❑ No

If yes, please list all medication you've taken for mental health.

Medication *Frequency* *Amount* *For What?*

____

____

____

____

Do you use alcohol or illegal drugs? ❑ Yes ❑ No

If yes, What? ___________________________________

How often? _______________________________

How much? _______________________________

Has this caused you problems (legal, occupational, family, social)? ❑ Yes ❑ No

Do you smoke or vape? ❑ Yes ❑ No Do you use chewless tobacco? ❑ Yes ❑ No

If yes, how much per day? ______________________

How many cups of caffeine do you drink per day (including tea, and soda)? ______________

Suicide & Homicide History

Have you ever attempted to commit suicide? ❑ Yes ❑ No

If yes, when and how? ____

Have you ever attempted to kill or seriously injure someone? ❑ Yes ❑ No

If yes, when and how? ____

Legal History

Are you currently in the process of a divorce? ❑ Yes ❑ No

Are you currently suing anyone or thinking of suing anyone? ❑ Yes ❑ No

If yes, please explain: ____

____

Is your reason for seeing help related to an accident or injury? ❑ Yes ❑ No

If yes, please explain: ____

____

Previous Treatment History

Have you previously been treated for a mental health issues? ❑ Yes ❑ No

If yes, how, by whom and when? ____

____

____

May we contact this person to get a copy of your records (we will need your signed authorization)

❑ Yes ❑ No

Presenting Problems

Please briefly describe your current difficulties and how you'd like us to help you:

____

____

____

____

____

____

If you could change one thing in your life, what would it be? ______________________________

____

____

Is there anything else you would like to mention to your therapist? __________________________

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____