Irons Counseling & Supervision
13625 Pond Springs Rd., Suite 105
Austin, Texas 78729

ADULT INFORMATION FORM

Date: _____/_____/_____ Therapist_____

Client name: _____

Preferred name / nickname: _____

Date of birth: _____/_____/_____ Age: _____ Gender: _____

Phone: _____ Ok to leave voice messages? Ok to text?

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation / Employer: _____

Relationship Status: Single Married Separated
Partnered Divorced Widowed

Emergency contact person: _____ Relation to you: _____

Emergency contact number:

How did you learn about this practice? _____

Do you have any children or dependents? If yes, list names and ages:

_____

_____

_____

What brings you to therapy at this point in time?

_____

_____

_____

_____

Check the number that represents the current severity of your concerns:

(Not Severe) 1 2 3 4 5 (Very Severe)

Are you currently having suicidal thoughts? (if yes, describe)

Have you had previous suicidal thoughts or attempts? (if yes, describe)

Please list any medical conditions (past or present) that may be contributing to your situation:

List any medications you are taking and their purpose:

Have you ever been hospitalized for mental health issues? (if yes, describe and list dates)

Please describe any recreational drug and/or alcohol use, or tobacco use, past or present (include frequency, amount & last use):

List and describe any previous counseling or psychiatric treatment you have received. Please list prior conditions, treatment(s), dates and from whom you received treatment:

Describe what was helpful and/or unhelpful from past therapy:

What other information would you like your therapist to know about you? (examples: birth trauma or postpartum anxiety/depression; family dynamics and history; major life changes; hobbies/interests; etc.)

What would feeling "better" look like for you? Describe your general goals for therapy:

Client Signature: _____ Date: _____

Therapist Signature:_____ Date: _____