



Adult Self-Report

The following questions are designed to gather information about you in an organized and efficient manner. This information is voluntary and may aid in the identification of conditions that are relevant to the mental health services provided to you at Crossroads Counseling Group. Please complete as much of this as you are comfortable with, and give this to your therapist directly. It will become a part of your clinical record.

Client Name: _____ Date: _____

Client Date of Birth: _____ Therapist Name (if known): _____

Please list all persons living in client's **current household** (exclude self):

Last Name	First Name	Relationship to client	Sex	Birth Date (or Year)	Health Status

Please list all persons in client's **family of origin** (your family growing up):

Last Name	First Name	Relationship to client	Sex	Birth Date (or Year)	Health Status

Ethnic Group: African Amer. ___ Asian ___ Bi-racial ___ Caucasian ___ Hispanic ___ Native Amer. ___ Other ___

Places you have lived:

City(town), State or Country	Dates lived there	Reason for move

Military Service: None ___ Veteran ___ Reserves ___ Active duty ___ Branch of Service: _____
 From what year to what year? _____ Where were you stationed? _____
 Combat zone experience? ___ Where? _____

Education History:

Grades 9-12 ___ HS grad ___ Some college ___ College grad ___ Post-grad degree ___ Vocational or Tech. degree ___
 High Schools attended & last year attended: _____

Colleges or Tech Schools attended (incl. years): _____

Major / Minor: _____

Graduate School(s) attended (incl. years): _____

Field / Area of study: _____

Vocational History:

What is your current vocation? _____

How many years have you been actively involved in this vocation? _____

Why did you get into this vocation? _____

Have you ever changed vocations? ___ If yes, from what to what? _____

Why? _____

What would you want to be or do if you were not in your present vocation? _____

Marital and Child-bearing History:

Current marital status: married ___ single ___ divorced ___ widowed ___ separated ___ other ___

Date married _____ Spouse's current age _____

Spouse's occupation _____

Ages you and spouse were when married client ___ spouse ___

Do you feel compatible with your spouse? ___ Why? _____

Please indicate **previous marital history:**

Client or current spouse?	Former spouse's name	The years married	Divorce / dissolution / death	Reason marriage ended

Have you & your current partner had any children together? How many? ____ Current age(s) _____
 Have you &/or your partner had any children with a different partner? ____
 If yes, how many children have you had? ____ Current age(s) _____
 If yes, how many has your partner had? ____ Current age(s) _____
 Have you with your current partner ever had any miscarriages? ____ If yes, how many? ____ When? _____
 Have you ever had any miscarriages with a previous partner? ____ If yes, how many? ____ When? _____
 Has your current partner ever had any miscarriages with a previous partner? ____ If yes, how many? ____ When? _____

Religious / Spiritual History:

Do you have any affiliation or membership with a specific church or religious community? Yes ____ No ____
 If yes, please share the name of the church or religious / faith community _____
 Do you identify with any particular religious or spiritual belief system? ____ If yes, please describe _____

 Do you practice any spiritual beliefs, customs or rituals that are not associated with a specific religious denomination? _____
 If yes, please describe _____
 If you are currently married, do you and your spouse share common religious or spiritual beliefs? ____ If no, please describe _____

 What role did religion play in your home life as a child? _____

 Have you had any significant hurtful or damaging experiences associated with religious / spiritual beliefs or practices? _____
 If yes, please describe _____

Mental Health History:

Have you ever experienced any significant losses? ____ If yes, please describe _____

 Have you ever experienced any significantly traumatic events? ____ If yes, please describe _____

 Have you had any prior mental health (or substance abuse) counseling, evaluation, or treatment? Yes ____ No ____
 List and describe:

Agency Name	Therapist / Doctor	Begin - End Dates	Reason

Presenting Concern (What concern has lead you to request counseling?):
 Share or describe the issue(s) for which you are seeking counseling. (Use a separate sheet of paper if needed.) Please feel free to go into detail regarding the related history of the concerns and the factors which have brought you to this point. It might also be helpful to describe any people - past and present - who are involved and their relationship to the issues. If you are able to identify a specific goal or goals for counseling, please do so as well.