



THE SIBLEY GROUP

Positive psychotherapy for families, couples & adults

Adult Information/History Form

Date: _____

Client Name _____

Date of Birth _____

Person completing this form _____

Relationship to client _____

What is your main concern and area of focus at this time for counseling?

What would you like to achieve during your sessions?

Where were you born and raised? _____

What were your experiences growing up? (i.e. grades, interests, peers, problems)

Elementary School: _____

Middle School: _____

High School: _____

College/Graduate: _____

What are your family relationships like currently?

Mother: _____

Father: _____

Siblings: _____

Other Extended Family: _____

What is your occupation and work history?

What are your hobbies and interests?

What is your experience with dating, marriage, and/or divorce and remarriage?

What have been your experiences with alcohol/drugs, loss, or trauma?

What do you consider your strengths?

What do you consider your challenges?

Please describe any relevant health concerns or medications.

Please list any past experiences with counseling or psychological/psychiatric treatment including medications or services:

Please check the **concerns, behaviors and/or positive traits** that fit most for you:

- | | |
|---|---|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Concern for others | <input type="checkbox"/> Responsible |
| <input type="checkbox"/> Mature | <input type="checkbox"/> Motivated |
| <input type="checkbox"/> Moody | <input type="checkbox"/> Self-harming behaviors |
| <input type="checkbox"/> Work problems | <input type="checkbox"/> Temper tantrums/rages |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Sexual problems/concerns |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Loving |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Artistic |
| <input type="checkbox"/> Immature/dependent | <input type="checkbox"/> Uncoordinated/accident prone |
| <input type="checkbox"/> Inattentive | <input type="checkbox"/> Suicide talk or attempt |
| <input type="checkbox"/> Withdraws/isolates | <input type="checkbox"/> Perfectionist |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Procrastinates |
| <input type="checkbox"/> Recent move/change | <input type="checkbox"/> Obedient |
| <input type="checkbox"/> Conflict with spouse | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Rocking/repetitive movements | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Peer conflicts | <input type="checkbox"/> Friendly, social |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Conflicts with parents |
| <input type="checkbox"/> Teased | <input type="checkbox"/> Fighting |
| <input type="checkbox"/> Musical | <input type="checkbox"/> Daydreams |
| <input type="checkbox"/> Smart | <input type="checkbox"/> Successful |
| <input type="checkbox"/> Talented | <input type="checkbox"/> Complaints of feeling sick |
| <input type="checkbox"/> Hard Working | <input type="checkbox"/> Negative |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Reliable |
| <input type="checkbox"/> Helpful | <input type="checkbox"/> Fun |
| <input type="checkbox"/> Avoids | <input type="checkbox"/> Loyal |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Shy/timid |
| <input type="checkbox"/> Works too much | <input type="checkbox"/> School avoidance |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Athletic |
| <input type="checkbox"/> Difficulty with rules | <input type="checkbox"/> Lethargic |
| <input type="checkbox"/> Drug/alcohol use | <input type="checkbox"/> Tics |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Flexible |
| <input type="checkbox"/> Liked by peers | <input type="checkbox"/> Legal problems |

