Laura L. Sparkman, M.S, LPC, NCC

Adult Background Form
CONFIDENTIAL

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed.

*Name:*_____________________________________ *First Visit Date:*____________________
Last First MI
Gender Identification: Male__ Female__ Other: ______________________________________
*Date of Birth*__________________________ *Age*______________________________
*Occupation:*____________________________ *Length of Time at this Job:*_______________
Ethnicity:
African American___ Bi-racial___ Hispanic/Latino___
Asian___ Caucasian___ Native American___ Other__________

Primary language: English ___ Spanish ___ Other ___

CONTACT INFORMATION

Cell Phone: _____________________ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Home Phone: ____________________ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Work Phone: ____________________ (***May call?*** Yes No ***May Leave Message?*** Yes No)
Best Time and Place to call:____
Mailing Address:____
Street City State Zip
May I correspond with you via mail at the above address: Yes No

In case of emergency, I authorize Laura Sparkman to contact:
____
Name: Last, First Relationship Phone
Person responsible for financial arrangement: ____
Name: Last, First
Who referred you? (Please be specific): ____
May I contact this referral source to thank them for the referral: Yes No

Note: There will be a charge for all sessions not cancelled within 24 hours.

CURRENT CONCERNS

General reason(s) for seeking counseling services at this time:

____

____

____

*Circle all items that you see as ongoing struggles in your life that you would like to work on in counseling

Issues Related to Abuse
Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment/rejection
Suspected sexual abuse
History of family domestic violence

Mood-Related Concerns
Disturbing memories
Difficulty going to sleep/Staying asleep
Nightmares/Night terrors
Suicidal thinking or talking
Suicidal attempting
Sadness/Depression
Feelings of guilt and shame
Excessive worrying or fear

Behavioral/Conduct Issues
Aggression toward others
Drug/alcohol use
Hyperactive/Impulsivity
Excessive computer use
Lying
Betraying relationships
Intentionally hurting animals
Fire-setting

Career/Academic Issues
Colleague/Cohort problems
Harassment issues
General work performance issues
Failing grades
Chronic stress
Career dissatisfaction
General problems at work/school

Family Relationship Concerns
Difficulty adjusting to family changes
Parenting/Discipline concerns
Parent-child relationship problems
Divorce
Separation
Religious/Spiritual Concerns
Estranged relationships
Constant fighting

Other Behavioral Concerns
Sexual identity questioning
Sexual issues in general
Appetite/Eating concerns
Sleep problems
Time management concerns
Inattentive
Lonely
Bored with Life

Other unusual behaviors (please specify)____

Please place a star by the most significant issue

Other unusual behaviors or recent changes in your life:

____

____

Please briefly discuss the above behaviors you have concerns about:

____

____

____

When did you first become concerned about these issues?
____
____

Why, at this point, have you decided to pursue counseling for the concern(s) above:
____
____

1. *Are you presently receiving counseling services elsewhere?* Yes No
2. *Have you ever seen a mental health professional (a psychologist, therapist, counselor, etc.)*? Yes No

   a. *Previous Mental Health Professional/Agency:*____________________________________
   b. *Phone:*____________________
   c. *Services Dates:*_________________________*(beginning-ending)*
   d. *Reason for seeking counseling services:*____
   e. *Describe the outcome of the counseling experience:*______________________________
   ____
   ____

3. *Have you been hospitalized for mental health concerns?* Yes No
   a. *If yes, When:*_____________ *Where:*____
   b. *Reason:*____

4. *Are you seeking services because you are a victim of a crime?* Yes No
   a. *Did it result in legal action?* Yes No *If yes, explain:*_________________________
   ____

5. *Are you seeking services for possible court advocacy (custody issues, abuse testimony, etc.)?* Yes No
   a. *If yes, please explain:*____
   ____
   ____

6. *Are you currently on probation?* Yes No

7. *Have you ever been suicidal?* Yes No

If yes, please explain when and what happened:
____
____
____

CURRENT LIVING ARRANGEMENTS

Family of origin ____ *Single* ____ *Spouse/Partner* ____ *Roommate* ____ *Other* ____

Marital Status:

Never married ____ *Currently married* ____ *Divorced* ____

History of learning issues/behavioral/conduct problems: Yes No
*If yes, please explain:*____

History of addictions (alcohol/drug/substance abuse, gambling, sex, pornography, etc): Yes No
*If yes, please explain:*____

History of family violence: Yes No
*If yes, please explain:*____

History of criminal activity: Yes No
*If yes, please explain:*____

History of protective order: Yes No
*If yes, please explain:*____

History of eating disorders (anorexia, bulimia, binge eating, laxative use, pica-eating inanimate objects, etc.): Yes No
*If yes, please explain:*____

History of self harming behavior (cutting, burning, etc.): Yes No
*If yes, please explain:*____

GENERAL HOUSEHOLD INFORMATION

List the members in your household, beginning with the oldest member (include the child.)
How long in this current living situation? _______

Name	Age	Gender	Relationship to self (include half/step/etc.)

If divorced/separated, circle the number which best describes your relationship with your child's other parent.

Hostile Frustrating Friendly
1_______________2_______________3_______________4_______________5

When did the divorce/separation occur?____
How often does the child see the other parent?____
Describe the visitation schedule:____
____

PHYSICAL/MENTAL HEALTH HISTORY

Primary Care Physician

*Name:*______________________________ *Phone:*__________________

*Address:*____

*Date of last physical:*_______________

Physical Disability: Yes No *(If yes, explain)*_____________________________________

Chronic Illness: Yes No *(If yes, explain)*_____________________________________

Terminal Illness: Yes No *(If yes, explain)*____________________________________

Allergy History: Yes No *(If yes, explain)*_____________________________________

Hospitalization History (medical issues only)-please describe:

____

____

____

____

Have you ever seen a psychiatrist? Yes No

Are you currently seeing a psychiatrist? Yes No

(If yes, please list contact information):

*Name:*______________________________ *Phone:*__________________

*Address:*____

What diagnosis have you received from a medical professional (or previous mental health professional)? (Ex: ADD/ADHD, Anxiety, Depression, Bipolar Disorder, Schizophrenia, Personality Disorders, etc.)

____

____

____

What medication(s) are you currently taking (including psychotropic and over-the-counter, etc.)?

Medication Dosage Reason

____

____

____

____

____

History of health/physical/mental symptoms includes (circle all that apply):

Asthma	Dizziness	Panic Attacks
Amnesia of large parts of childhood after age 5	Hallucinations-Auditory	Nervous stomach
	Hallucinations-Vision	Neurological problems/exam
Bedwetting	Hallucinations-Tactile	Severe PMS
Bone/joint/muscle	Severe Headaches	Serious over/under eating
Chest pain	Heart Palpitations	Shortness of breath without exertion
Chronic Illness	Hospitalization	
Developmental delay(s)	Major accident	Sleep problems
Chronic Diarrhea	Major Illness	Sleep walking
Disability	Memories/flashbacks	Surgeries

*Please describe circled items:*____
____
*Daily exercise/physical activity habits:*____
*Daily caffeine intake:*____
*How would you describe your overall diet?*____
*Average hours of sleep per night:*__________
*Are sleep patterns consistent?*____

HISTORY OF LIFE STRESSORS

***Note your approximate age at the time of the occurrence of the following items:
Chronic illness of family member ____ Death of significant person ____ Domestic violence ____
Family member absent ____ *Explain:*____
Family member's disability/major accident ____ *Explain:*_______________________________
Family member's emotional problems ____ *Explain:*__________________________________
Family member's suicide ____ *Explain:*____
Child separated from parent ____ *Explain:*____
Parent's divorce ____ Death of a pet ____ Difficult medical treatments ____
Natural Disaster ____ Sexual assault ____
Other trauma/experience(s) that may have impacted you significantly: ____
*Explain:*____

I agree that the above information is accurate to the best of my ability. I also understand if I have any questions regarding the above questions, I may ask these questions at any time.

____

Client/Guardian Date

Ignite the Spark

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