Empathic Life Solutions
COUNSELLING | TRAINING | CONSULTING

Adult Self-Report Form

Name: _____

Date of Birth (dd/mm/yr): _____

Address: _____

Phone number: _____Can we leave a message at this number? Yes No

Email Address_____

Marital Status: ☐ Single ☐ Common-law ☐ Married ☐ Separated ☐ Divorced

☐ Widowed ☐ Other _____

Spouse/Partner's name: _____ Date of Birth (dd/mm/yr):_____

Emergency Contact: _____ Relationship to you: _____

Phone number: _____

How did you hear about our services? _____

Do you have children? Yes No

If yes, please indicate:

Name	Gender	Date of Birth

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

Clinic name: _____

Phone: _____

Doctor's name: _____

Address: _____

Your current employer

Employer: _____

Work phone: _____Can I leave a message at this number? Yes No

Address: _____

Occupation: _____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Yes No

If yes, please indicate:

When: _____

From Whom: _____

For What: _____

Results: _____

Have you ever taken medications for psychiatric or emotional problems? Yes No

If yes, please indicate:

When: _____

What medications: _____

From Whom: _____

For What: _____

Results: _____

Chief Concern

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

_____

List of Symptoms

Please circle any of the following that have been bothering you lately:

abused as child	abuse in past relationship	abuse in current relationship
addictions	alcohol use	ambition
anger	anxiety	appetite
being a parent	career choices	children
communication	compulsions	concentration
depression	divorce/separation	drug use/abuse
eating problem	education	energy (hi/low)
extreme fatigue	fears	finances
grief	guilt	health problems
inferiority feelings	insomnia	loneliness
making decisions	marriage	memory
my thoughts	nervousness	nightmares
obsessive thinking	overweight	painful thoughts
panic attacks	phobias	relationships
sadness	self-esteem	self-harm
separation	sexual problems	short temper
shyness	sleep	stress
suicidal thoughts	work	

Other symptoms not listed above:

_____

_____

_____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life (circle appropriate response):

Marriage / Relationship: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Family: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Job/school performance: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Friendships: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Financial situation: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Physical health: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Anxiety level / nerves: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Mood: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Eating habits: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Sleeping habits: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Sexual functioning: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Alcohol / drug use: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Ability to concentrate: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Ability to control anger: ☐ Not Applicable

1 - No effect 2 – Little effect 3 – Some effect 4 – Much effect 5 – Significant effect

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

If yes, what drugs do you use? _____

How many days per week do you consume drugs and what amount? _____

_____

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No

Have family members or friends expressed concern about your drinking or drug use? Yes No

Do you have a family history of alcohol or drug problems? Yes No

If yes, please describe:

_____

_____

Other

Is there anything else that is important for me as your therapist to know about and that you have not written about on any of these pages? Please tell me here:

_____

_____

_____