Ariella Soffer, Ph.D., PLLC
240 Central Park South, Ste. 8C
New York, NY 10019
646-300-5095

Adult History and Checklist of Concerns

Name:_____ Date:_____

Date of Birth:_____ Age:_____

Address:_____

Phone Contact: (please check one box for preferred number)

☐Home:_____ ☐Cell:_____ ☐Work:_____

E-mail address:_____

Referral Source:_____

Occupation:_____ Current Employer:_____

Emergency Contact Information:

Name: _____ Relationship:_____ Phone Number:_____

Marital Status: ☐Single/Never Married ☐Married ☐Separated ☐Divorced ☐Widowed

Please Indicate Names, Gender and Ages of Your Children, if Any:

Name:_____ Gender:_____ Age:_____

Name:_____ Gender:_____ Age:_____

Name:_____ Gender:_____ Age:_____

Name:_____ Gender:_____ Age:_____

Family of Origin History (please answer only for the significant relatives in your life):

Relative	Name(s)	Current Age (or age at death)	Illnesses (or cause of death, if deceased)	Highest Education	Occupation
Father					
Mother					
Stepparents					
Brothers					
Sisters					
Step-siblings					
Grandparents					
Other significant family relationships (describe): _____					

Marital History:

	Spouse's Name	Spouse's Age at Marriage	Your Age at Marriage	Your Age When Divorced/ Widowed	Spouse's Occupation
Current					
First					
Second					

Significant Nonmarital/Romantic Relationships:

	Name of Other Person	Person's Age When Started	Your Age When Started	Your Age When Ended	Reason for Ending
Current					
First					
Second					
Third					

Educational History:

	Name of School	Dates Attended
High School:	_____	_____
College:	_____	_____
Graduate School:	_____	_____

Treatment History:

Have you ever received psychotherapy, counseling, or drug/alcohol treatment before?

☐No ☐Yes (If Yes, please indicate):

Dates of treatment	Provider/Facility Name	Reason for treatment	Treatment helpful/effective?
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No
_____	_____	_____	☐Yes ☐No

Have you ever taken medications for psychiatric or emotional difficulties?

☐No ☐Yes (If Yes, please indicate):

Dates Taken	Prescribing Physician	Medication Name	Reason for Medication	Results

Please indicate if any of the following is a current or past concern (any time in the past):

	Current Concern	Past Concern
Suicidal thoughts	☐	☐
Suicide attempts/gestures	☐	☐
Inpatient psychiatric hospitalization	☐	☐
Self-mutilation/self-harm	☐	☐
Alcohol use	☐	☐
Drug use: prescription medications, OTC medications, street drugs	☐	☐
History of aggression/violence/threats toward others	☐	☐

If you checked any of the boxes above, please provide details:

_____

_____

_____

_____