Joy K Adle, LMHC
License # MH14012
561-676-4298

Client History, Information and Goals

NAME:_____ DATE:_____

Date of your last doctor appointment:

Major medical injuries, illnesses, or surgeries:

Current medications you are taking (name, dosage, prescribing MD):

Psychiatric medications you have taken in the past (name, dosage, start/stop date):

Please list any substances you use (alcohol, marijuana, caffeine, tobacco, heroin, psychedelics, methamphetamine, etc):

Please list past therapies and/or psychiatric hospitalizations:

Psychiatric disorders in immediate or extended family:

Describe your current support system (family, friends, organizations, etc.):

Do you ever have thoughts about hurting yourself or others? Yes ___ No _____
If yes, please describe.

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes or dreams?

What are your goals for therapy?

1)

2)

3)