Oria Health and Wellness Inc.
FLORENCE MALMGREN, LMFT
11858 BERNARDO PLAZA COURT, SUITE 210, SAN DIEGO, CA 92128
PHONE 858-524-4300
WWW.ORIATHERAPY.COM

# Adult Information Form

| | | | | |
|---|---|---|---|---|
| **Name:** | | | | **Date:** |
| Date of Birth: | | Age: | | |
| Home Address: | | City: | | Zip: |
| Home Phone: | | Cell Phone: | | |
| Email: | ☐ Ok to send me an email | ☐ Encrypted only | | |
| Preferred Method of Contact: | ☐ Home Phone | ☐ Cell Phone | ☐ Email | |
| OK to send automatic SMS reminders? | ☐ Yes | ☐ No | | |
| OK to leave a message with name and call back # on answering machine/voicemails? | ☐ Yes | ☐ No | | |
| **Relationship Status:** | ☐ Single/not dating<br>☐ Single/Dating | ☐ Married<br>☐ Divorced | ☐ Committed relationship | ☐ Widowed<br>☐ Other |
| **Parental Status:** | ☐ No Children<br>☐ Foster parent | ☐ Biological Parent<br>☐ Adoptive Parent | ☐ Step/Co-parent<br>☐ Legal Guardian | ☐ Other |
| Child's Name: | | Age: | Grade: | |
| Child's Name: | | Age: | Grade: | |
| Child's Name: | | Age: | Grade: | |
| Child's Name: | | Age: | Grade: | |
| **Answer the information in the next 3 rows Only if you would like to share at this time:** | | | | |
| **Ethnicity:** | ☐ African American<br>☐ American/Alaskan Indian | ☐ Asian<br>☐ Anglo | ☐ Hawaiian/Pacific Highlander<br>☐ Caucasian | ☐ Latino/a<br>☐ Other |
| **Religion:** | ☐ Catholic<br>☐ Buddhist | ☐ Protestant<br>☐ Hindu | ☐ Jewish<br>☐ Islamic | ☐ Christian<br>☐ Other |
| **Affectional/Sexual Orientation** | ☐ heterosexual | ☐ Lesbian/Gay | ☐ Bisexual | ☐ Uncertain |

| | | |
|---|---|---|
| **Emergency Contact: please identify an individual that we may contact in the event of an emergency** | | |
| Name: | | Relationship to You: |
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | |

| | | | |
|---|---|---|---|
| **Insurance Information** | | | |
| Insured Person Name: | | | |
| Is address of patient same as that of Insured person? | ☐ Yes | ☐ No | |
| If No, please write address of insured person: | | | |
| Patient's relationship to insured person: | | | |
| Name of Primary Insurance: | | | |
| Insurance Policy #: | | | |
| ID# | Group# | Effective date: | |
| Insurance Address: | | Phone: | |
| City: | State: | Zip: | |

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| | |
|---|---|
| Employer Name: | Job Title: |
| Spouse/Partner Employer Name: | Job Title: |

**Highest Level of Education Completed:**

☐ Some High School ☐ High School Diploma ☐ Some College ☐ Technical/Apprentice Cert.
☐ AA Degree ☐ BA/BS Degree ☐ MA/MS Degree ☐ MD/ PHD

**Please fill in the chart of your current living situation**

| NAME | AGE | RELATIONSHIP | SCHOOL/OCCUPATION |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please describe Briefly your relationship with your family of origin:**

| |
|---|
| Mother |
| Father |
| Siblings |

**Health History**

| | | |
|---|---|---|
| Primary Physician Name: | Phone: | Last exam: |
| Address: | | |
| City: | State: | City |
| Do you have any chronic or recurrent medical problems or disabilities: | ☐ Yes | ☐ No |
| Please list: | | |
| Do you have any recent serious illness or injuries? | ☐ Yes | ☐ No |
| Please List: | | |
| Are you currently on the following? | ☐ Disability | ☐ Worker comp |
| More Health Info: (allergies, Thyroid function, etc..) | | |

**Current Medications (prescribed/over the counter/holistic)**

| Medications | Reason | Dosage | Side effects | Helpful? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Psychological History: Have you ever seen a Therapist or a Psychiatrist?**

| | | | |
|---|---|---|---|
| Psychiatrist name: | Phone: | Dates: | |
| Address: | City: | State: | Zip: |
| Therapist Name: | Phone: | Dates: | |
| Address: | City: | State: | Zip: |

Please list the reasons for seeking help and how the services helped or did not help you?

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| **Current Presenting Problem/ Concern: (Please describe in your own words what brings you to therapy)** |
|---|
| |

| **Symptoms/Complaints** | | |
|---|---|---|
| ☐ Anxiety | ☐ Memory Problem | ☐ Sexual Problem |
| ☐ Panic Attacks | ☐ Problem sleeping | ☐ Substance Use |
| ☐ Guarded | ☐ Problem eating | ☐ Flashbacks |
| ☐ Agitated/Worry | ☐ Problem with concentrating | ☐ Trauma |
| ☐ Phobia/Fears | ☐ Low self-esteem | ☐ Angry Outburst |
| ☐ Obsessions/ Compulsions | ☐ Hopeless | ☐ Impulsive |
| ☐ Crying spells/tearful | ☐ Helpless | ☐ Paranoid |
| ☐ Depression | ☐ Confused | ☐ Dissociation |
| ☐ Suicidal Past___Present___ | ☐ Self-Blame | ☐ Hallucinations |
| ☐ Withdrawn | ☐ Difficulty Asserting Myself | ☐ Delusions |
| ☐ Fatigue | ☐ Attention Problem | ☐ Oppositional/ Defiant Behavior |
| ☐ Isolative | ☐ Hyperactivity | ☐ Learning Disability: |
| ☐ Lack of Energy | ☐ Somatic Problem | ☐ Self-Mutilation |
| ☐ Difficulty Concentrating | | |
| **Stressors** | | |
| ☐ Financial Problems | ☐ Injuries or illness | ☐ Sleep |
| ☐ Recent Loss | ☐ Conflict: Parent-Child | ☐ Legal problems |
| ☐ Divorce | ☐ Conflict between spouses | ☐ Children problems at school |
| ☐ Move | ☐ Unemployment | ☐ Abuse/Neglect |
| **Others Symptoms or Stressors:** | | |
| Have you ever attempted suicide? ☐ Yes ☐ No Date: Explain: | | |

| **Drug and Alcohol History** | | | | |
|---|---|---|---|---|
| Did You ever use drugs? ☐ Yes ☐ No | | Did you ever abuse alcohol? ☐ Yes ☐ No | | |
| Please check drug(s) used in past: | | | | |
| ☐ Marijuana | ☐ Speed | ☐ Acid | ☐ Heroin | ☐ Tranquilizers |
| ☐ Cocaine | ☐ Inhalants | ☐ Crystal/Meth | ☐ Crack | ☐ PCP |
| ☐ Prescriptions | ☐ Other | Age started: | | |
| Do you currently use drugs? ☐ Yes ☐ No | | | | |
| Please check drug(s) currently used: | | | | |
| ☐ Marijuana | ☐ Speed | ☐ Acid | ☐ Heroin | ☐ Tranquilizers |
| ☐ Cocaine | ☐ Inhalants | ☐ Crystal/Meth | ☐ Crack | ☐ PCP |
| ☐ Prescriptions | ☐ | ☐ | ☐ | ☐ Other |
| Any history of losses or of the following due to Substances/alcohol? | | | | |
| ☐ Arrest(s) | ☐ DUI(S) | ☐ Job loss(es) | ☐ Debts | ☐ Other |