

ADULT REGISTRATION

Name: _____ **Sex:** Male Female

Date of Birth: _____ **Place of Birth:** _____

Religion (optional): _____

Full Time Student **Part Time Student**

Presenting Problem(s): (check all that apply)

- | | | |
|--------------------------------------------|---------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Very unhappy | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Stealing | <input type="checkbox"/> Temper outbursts |
| <input type="checkbox"/> Lying | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Sexual trouble |
| <input type="checkbox"/> Daydreaming | <input type="checkbox"/> School performance | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Destructive | <input type="checkbox"/> Clumsy | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Overactive | <input type="checkbox"/> Slow | <input type="checkbox"/> Suicide talk |
| <input type="checkbox"/> Self-mutilation | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Distractible | <input type="checkbox"/> Sickly |
| <input type="checkbox"/> Lacks initiative | <input type="checkbox"/> Shy | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Undependable | <input type="checkbox"/> Strange behavior | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Peer conflict | <input type="checkbox"/> Strange thoughts | |
| <input type="checkbox"/> Phobic | | |

Explain: _____

How long have these problems occurred? (number of weeks, months, years) _____

What happened that makes you seek help at this time? _____

Problems perceived to be: very serious serious not serious

What interventions have you used in the past? _____

Were any of the above interventions effective? Yes No If yes, which one(s): _____

What changes would you like to see in yourself? _____

What changes would you like to see in your family? _____
