

**Mark J. Hirschmann, PhD LMFT**

**Adult Background Form**

State of Wisconsin Statutes protects the confidentiality of clients who share information with a licensed marriage and family therapist. Notable exceptions are disclosures of child abuse and imminent danger to yourself or others.

Additional room to complete answers is available on the third page or on the back of these pages.

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

**Areas of Concern**

What issues/concerns caused you to seek treatment? Please describe. \_\_\_\_\_  
\_\_\_\_\_

Do you have any specific goals with regard to your treatment? \_\_\_\_\_  
\_\_\_\_\_

Do you have any particular concerns/fears with regard to treatment? \_\_\_\_\_  
\_\_\_\_\_

Life stressors in the last year? \_\_\_\_\_  
\_\_\_\_\_

**General Information**

Educational level: \_\_\_\_\_ Occupation: \_\_\_\_\_

Briefly describe your social support system: \_\_\_\_\_  
\_\_\_\_\_

Preferred telephone number: \_\_\_\_\_ May I leave a message? \_\_\_\_\_

Email: \_\_\_\_\_ May I contact you to describe additional services? \_\_\_\_\_

**Psychological History** (Requests for information about treatment requires additional authorization from you.)

Describe previous mental health outpatient treatment: \_\_\_\_\_

When and for how long? \_\_\_\_\_

What was the focus of treatment: \_\_\_\_\_

**Page 2: Psychological History** (continued)

Names of treating therapist(s), address(es), telephone number(s) \_\_\_\_\_

---

Have you ever taken one or more psychological tests? \_\_\_\_\_ If so, by whom? \_\_\_\_\_

Have you ever been hospitalized for mental health? \_\_\_\_\_ If so, when and for how long? \_\_\_\_\_

Name of treating therapist, address, telephone number: \_\_\_\_\_

Have you ever taken any medications for a mental or emotional condition \_\_\_\_\_ If so, when and for how long?

---

Have you ever attempted suicide? \_\_\_\_\_ If so, when and related to which circumstances: \_\_\_\_\_

---

Are you currently having any suicidal thoughts? \_\_\_\_\_ or thoughts of hurting others? \_\_\_\_\_

If so, please describe. \_\_\_\_\_

Have you ever hurt yourself intentionally by cutting or other means? \_\_\_\_\_

Briefly describe your childhood. \_\_\_\_\_

---

Describe the saddest time in your childhood. \_\_\_\_\_

Who held and comforted you as a child? \_\_\_\_\_

Were you subjected to verbal, physical, emotional, or sexual abuse? \_\_\_\_\_ If so, please describe. \_\_\_\_\_

---

What was the saddest time of your adult life? \_\_\_\_\_

Have you ever been the victim of a violent crime? \_\_\_\_\_ If so, please describe on page 3.

Have you ever been convicted of a serious crime? \_\_\_\_\_ If so, please describe on page 3.

Do you have any physical symptoms associated with your mental or emotional health? \_\_\_\_\_

Have you ever been in a 12-step program? \_\_\_\_\_ If so, please describe. \_\_\_\_\_

How many drinks of alcohol do you average per week? \_\_\_\_\_

List family members who have abused alcohol or drugs. \_\_\_\_\_

Which prescription or over-the-counter medications do you take? Please list dosages and frequencies.

---

**Page 3: Family**

Do you currently use illegal drugs? If so, please describe. \_\_\_\_\_

Have you ever used illegal drugs? If so, please describe. \_\_\_\_\_

Mother's name, age, living/deceased, your age at mother's death, description of relationship with mother. \_\_\_\_\_

---

Father's name, age, living/deceased, your age at your father's death, description of relationship with father. \_\_\_\_\_

---

Ages and genders of your siblings. \_\_\_\_\_

Name of spouse or partner, \_\_\_\_\_ Year Married \_\_\_\_\_

From 0 to 10 (with 10 being high), rate the degree to which your spouse currently cares about you. \_\_\_\_\_

Names of former spouses or partners, \_\_\_\_\_ Year married: \_\_\_\_\_

Names and ages of children: \_\_\_\_\_

**Other Information**

Please describe your spiritual identity/orientation. \_\_\_\_\_

Please describe your interests/hobbies. \_\_\_\_\_

Are you now or have you ever been involved in a lawsuit? \_\_\_\_\_ If so, please describe. \_\_\_\_\_

---

Please feel free to include any other information, that you believe is relevant to your mental health treatment, not previously requested. \_\_\_\_\_

---

---

---

**Room for extended responses (use the back of the page if necessary):**

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_