

CAMP HILL (Main Office/Billing Address)  
207 House Ave, Suite 109  
Camp Hill, PA 17011

**LifeSpire, LLC**  
[www.LifeSpirePA.com](http://www.LifeSpirePA.com)  
717-745-6166

HERSHEY  
523 W. Chocolate Ave, 2<sup>nd</sup> Floor  
Hershey, PA 17033

## Adult Information Sheet

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_  Cell/  Work Phone: \_\_\_\_\_

**Relationship Status:**

Never Married     Married     Partnered     Divorced     Separated     Widow / Widower

How did you hear about this practice? Who referred you?

Please list anyone living you with you:

Name	Age	Relationship to you	Occupation

Briefly describe what brings you in:

### SOCIAL HISTORY

Highest Level of Education Obtained: \_\_\_\_\_

Current Occupation/Job Title: \_\_\_\_\_

Employer: \_\_\_\_\_ # of years employed here: \_\_\_\_\_

Please describe your spiritual/religious affiliation: \_\_\_\_\_

## MENTAL HEALTH BACKGROUND

- At this time, have you ever had thoughts to harm yourself or end your life?     YES     NO
- Have you ever attempted suicide or intentionally harmed yourself?     YES     NO
- Have you ever had thoughts to harm other people?     YES     NO

Please list any previous mental health treatment and/or substance abuse treatment:

Treatment Dates	Name of Provider/Agency	Reason for Treatment	Treatment Success

## LEGAL HISTORY

- Have you ever been arrested?     YES     NO
- Have you ever been arrested for a DUI/DWI?     YES     NO
- Have you ever been in prison?     YES     NO
- Are you currently involved in any litigation or legal matters?     YES     NO

If you answered "Yes" to any of the above, please describe:

## MEDICAL HISTORY

Name of Primary Care Physician or Provider (address/phone#):

How would you describe your physical health?

- Excellent     Good     Average     Poor     Very Poor

List any medical conditions that you have:

CAMP HILL (Main Office/Billing Address)

207 House Ave, Suite 109

Camp Hill, PA 17011

# LifeSpire, LLC

[www.LifeSpirePA.com](http://www.LifeSpirePA.com)

717-745-6166

HERSHEY

523 W. Chocolate Ave, 2<sup>nd</sup> Floor

Hershey, PA 17033

**List any prescription or over-the-counter medications you are taking:**

Medication/Drug	Dose/Frequency	When started	For what symptoms

Do you have any allergies or sensitivities to drugs, food, or other substances?  YES  NO

Do you smoke or use other tobacco products?  YES  NO

Do you use recreational drugs (marijuana, cocaine, or other drugs)?  YES  NO

**If there is any other information that you believe would be helpful for me to know, please describe below:**