Personal History Form
Adult (18+)

Client's Name: ______________________________ Date: ______________

Gender: _____ F _____ M Date of Birth: ______________

Form completed by (if different than consumer): ______________________

Address: ____

City: ______________________________ State: ______________

Phone (cell): ______________________ (home): ______________________

Email address: ____

Preferred Method of Communication: ______________________________

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

_____ Anger Management _____ Anxiety _____ Coping

_____ Eating Disorder _____ Depression _____ Fear/Phobias

_____ Mental Confusion _____ Sexual Concerns _____ Alcohol/Drugs

_____ Sleeping Problems _____ Addictive Behaviors

Other mental health concerns (specify): ______________________________

Family Information

			Living		Living w/you	
Relationship	**Name**	**Age**	**Yes**	**No**	**Yes**	**No**
1. ____________	____________	____	____	____	____	____
2. ____________	____________	____	____	____	____	____
3. ____________	____________	____	____	____	____	____
4. ____________	____________	____	____	____	____	____
5. .____________	____________	____	____	____	____	____
6. .____________	____________	____	____	____	____	____
7. .____________	____________	____	____	____	____	____
8. .____________	____________	____	____	____	____	____
9. .____________	____________	____	____	____	____	____

Significant others: (brothers, sisters, grandparents, step-relatives, half-relatives). Please specify relationship.

	Relationship	Name	Age	Living Yes	Living No	Living w/you Yes	Living w/you No
1.	________	________	____	____	____	____	____
2.	________	________	____	____	____	____	____
3.	________	________	____	____	____	____	____
4.	________	________	____	____	____	____	____
5. .	________	________	____	____	____	____	____
6. .	________	________	____	____	____	____	____
7. .	________	________	____	____	____	____	____

Marital Status: (more than one answer may apply)

____ Single

____ Divorce in process
Length of time _____

____ Unmarried, living
living together

____ Legally Married
Length of time ____

____ Separated
Length of time ____

____ Divorced
Length of time ____

____ Widowed
Length of time ____

____ Annulment
Length of time ____

Total # of marriages ___

Assessment of current relationship (if applicable): _____ Good ____ Fair ____ Poor

Parental Information:

____ Parents legally married
____ Mother Remarried Number of times: _______
____ Father Remarried Number of times: _______
____ Parents Separated
____ Parents Divorces

Special circumstances (raised by person other than parents, information about spouse/children not living with you, etc.)

____

____

____

____

Development:

Are there special, unusual, or traumatic circumstances that affected your development?

____ Yes ____ No

If yes, please describe:____

Has there been history of child abuse? ____ Yes ____ No

If yes, which type(s)? ____ Sexual ____ Physical ____ Verbal

If yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: ____ Neglect ____ Inadequate nutrition ____ Other

If other, please explain: ____

Comments regarding childhood development: ______________________________

____

____

Medical/Physical Health:

____ AIDS	____ Dizziness	____ Nose Bleeds
____ Alcoholism	____ Drug Abuse	____ Pneumonia
____ Abdominal	____ Epilepsy	____ Rheumatic Fever
____ Abortion	____ Ear Infections	____ Sexually Trans. Disease
____ Allergies	____ Eating Problems	____ Sleeping Disorders
____ Anemia	____ Fainting	____ Sore Throat
____ Appendicitis	____ Fatigue	____ Scarlet Fever
____ Arthritis	____ Frequent Urination	____ Sinusitis
____ Asthma	____ Headaches	____ Small Pox
____ Bronchitis	____ Hearing Problems	____ Stroke
____ Bed Wetting	____ Hepatitis	____ Sexual Problems
____ Cancer	____ High Blood Pressure	____ Tonsillitis
____ Chest Pain	____ Kidney Problems	____ Tuberculosis
____ Chronic Pain	____ Measles	____ Toothache
____ Colds/Coughs	____ Mononucleosis	____ Thyroid Problems
____ Constipation	____ Mumps	____ Vision Problems
____ Chicken Pox	____ Menstrual Pain	____ Vomiting
____ Dental Problems	____ Miscarriages	____ Whooping Cough
____ Diabetes	____ Neurological Disorders	____ Other
____ Diarrhea	____ Nausea	

Medical/Physical Cont.

List any current health concerns: ____

____

List any recent health or physical changes: ______________________________________

____

Nutrition:

Meal	**How often (times per week)**	**Typical foods eaten**	**Typical amount eaten**
Breakfast	____ / week	____________________	___No ___ Low ___ Med ___High
Lunch	____ / week	____________________	___No ___ Low ___ Med ___High
Dinner	____ / week	____________________	___No ___ Low ___ Med ___High
Snacks	____ / week	____________________	___No ___ Low ___ Med ___High

Comments: ____

Current Prescribed Medications	Dose	Dates	Purpose	Side Effects

Current Over The Counter Meds.	Dose	Dates	Purpose	Side Effects

Are you allergic to any medications or drugs? ____ Yes ____ No

If yes, describe: ____

____

	Date	Reason	Results
Last physical exam			
Last doctors visit			
Last dental exam			
Most recent surgery			
Upcoming surgery			

Family History of Medical Problems: ____

____

____

Please check if there have been any recent changes in the following:

_____ Sleep patterns _____ Eating patterns _____ Behavior _____ Energy level

_____ Physical activity level _____ General disposition _____ Weight _____ Nervous Tension

Describe changes in areas in which you checked above: ______________________________

____

____

Leisure/Recreational:

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, diet health, hunting, fishing, bowling, etc.).

Activity	How Often Now	How Often in the Past
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Cultural / Ethnic

To which cultural or ethnic group, if any, do you belong? ____________________________

Are you experiencing any problems due to cultural or ethnic issues: _____ Yes _____ No

If yes, please describe: ____

____

Other cultural / ethnic information: ____

____

Social Relationships:

Check how you generally get along with other people (check all that apply):

____ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

___ Friendly ___ Leader ____ Outgoing ____ Shy/Withdrawn ____ Submissive

Other (specify): ____

Sexual Orientation: ___________________________ Comments: _________________________________

Sexual Dysfunctions: _________________________ Comments: _________________________________

Any current or history of being a sexual perpetrator? _____ Yes _____ No

If yes, please describe: ____

____

Spiritual / Religious:

How important to you are spiritual matters: ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? _____ Yes _____ No

If yes, describe: ____

Were you raised within a spiritual or religious group?: _____ Yes _____ No

If yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? __ Y __ N

If yes, describe: ____

Legal:

Current Status:

Are you involved in any active cases (traffic, civil, criminal)? _____ Yes _____ No

If yes, please describe and indicate the court and hearing/trial dates and charges: __________

____

Are you presently on probation or parole?: _____ Yes _____ No

If yes, please describe: ____

____

Past History:

Traffic Violations ____ Yes ____ No DWI, DUI, etc. ____ Yes ____ No

Criminal Involvement ____ Yes ____ No Civil Involvement: ____ Yes ____ No

If you responded YES to any of the above, please fill in the following information:

Charges	Date	Where (city)	Results
____________________	____________	_________________________	____________________
____________________	____________	_________________________	____________________
____________________	____________	_________________________	____________________
____________________	____________	_________________________	____________________

Education:

Fill in all that apply: Years of education: ____ Currently enrolled in school? ___ Yes ___ No

____ High School Grad/GED

__ Vocational Number of years: __ Graduated: __ Yes __ No Major: _________________

__ College Number of years: __ Graduated: __ Yes __ No Major: _________________

__ Graduate Number of years: __ Graduated: __ Yes __ No Major: _________________

Other Training: ____

Special Circumstances (e.g. learning disability, gifted): ________________________________

Employment:

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left	How often missed?
______________________	_________	__________	______________	_________________
______________________	_________	__________	______________	_________________
______________________	_________	__________	______________	_________________
______________________	_________	__________	______________	_________________

Currently: ____ FT ____ PT ____ Temp ____ Laid Off ____ Disabled ____ Retired

____ Social Security ____ Student (____ Part Time ____ Full Time)

Other: ____

Military:

Military ____ Yes ____ No Combat Experience ____ Yes ____ No

Where: ____

Branch: _________________________________ Discharge Date: ___________________________

Date enlisted: ________________ Rank at discharge: ____________________________________

Chemical Use History:

	Method of Use and amount	Frequency of use	Age of first use	Used in last 48 hours	Used in last 30 days
Alcohol	___	___	___	___	___
Barbiturates	___	___	___	___	___
Valium	___	___	___	___	___
Cocaine/Crack	___	___	___	___	___
Heroin/Opiates	___	___	___	___	___
Marijuana	___	___	___	___	___
PCP/LSD	___	___	___	___	___
Inhalants	___	___	___	___	___
Caffeine	___	___	___	___	___
Nicotine	___	___	___	___	___
Over the Counter	___	___	___	___	___
Prescription	___	___	___	___	___
Meth	___	___	___	___	___
Other Drugs	___	___	___	___	___
	___	___	___	___	___
	___	___	___	___	___

Substance of preference

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

Substance Abuse Questions:

Describe when and where you typically use substances:

____

Describe any changes in your use pattern:

____

Describe how your use has affected your family or friends: ______________________

____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other: ______________________

How do you believe your substance use affects your life: ______________________________

____

Who or what has helped you in stopping or limiting your use? ______________________

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If yes, describe: ____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol?

____ Yes ____ No If yes, describe: ____

Have you had adverse reactions or overdose to drugs or alcohol? ____ Yes ____ No

If yes, describe: ____

Does your body temperature change when you drink? ____ Yes ____ No

If yes, describe: ____

Counseling/Prior Treatment History:

	Yes	No	When	Where	Your reaction To experience
Counseling/Psychiatric treatment	____	____	________	________	__________
Suicidal thoughts/ attempts	____	____	________	________	__________
Drug/Alcohol Treatment	____	____	________	________	__________
Hospitalizations	____	____	________	________	__________
Involvement w/self-help (AA, NA, Al-anon)	____	____	________	________	__________

Information about family/significant other (past and present):

	Yes	No	When	Where	Your reaction To experience
Counseling/Psychiatric treatment	____	____	________	________	__________
Suicidal thoughts/ attempts	____	____	________	________	__________
Drug/Alcohol Treatment	____	____	________	________	__________
Hospitalizations	____	____	________	________	__________
Involvement w/self-help (AA, NA, Al-anon)	____	____	________	________	__________

Please check behavior and symptoms that occur to you more often that you would like them to take place.

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated Mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ High blood pressure
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___ Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Disorganized thoughts
___ Trembling
___ Withdrawing
___ Worrying
___ Other: ___________________
___ Other: ___________________

Briefly discuss how the above symptoms impair your ability to function effectively:

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____
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____

Any additional information that would assist me in understanding your concerns or problems:

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____

What are your goals for therapy?

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Do you feel suicidal at this time? _____ Yes _____ No
If yes explain:

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For Staff Use:

Therapist's signature/credentials: ____________________________ Date: _____________