PERSONAL HISTORY

Adult (18+)

Client Information

Client's Name: ______________________________ Date: ___/___/___

Gender: ☐ Female ☐ Male Date of birth: ___/___/___ Age: ______

Form completed by (if someone other than client): ______________________________

Address: ______________________ City: ______________ State: ____ Zip: _________

Home Phone: ________________ Work Phone: ________________ Ext: __________

Primary reason(s) for seeking services:

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression
☐ Eating disorder ☐ Fear/phobias ☐ Mental confusion ☐ Sexual concerns
☐ Sleeping problems ☐ Addictive behaviors ☐ Alcohol/drugs
☐ Other mental health concerns or behaviors (specify):

____
____
____

Family Information

IMMEDIATE FAMILY

Relationship	Name	Age	Living?	Living with you?
Mother			☐ Yes ☐ No	☐ Yes ☐ No
Father			☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ Yes ☐ No	☐ Yes ☐ No
Children			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

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Family Information (CONT.)

SIGNIFICANT OTHERS

E.g., brother, sisters, grandparents, step-relatives, half relatives. Please specify relationship.

Relationship	Name	Age	Living?	Living with you?
______	______	______	☐ Yes ☐ No	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No	☐ Yes ☐ No
______	______	______	☐ Yes ☐ No	☐ Yes ☐ No

MARITAL STATUS

More than one answer may apply.

☐ Single

☐ Divorce in process
Length of time: __________

☐ Unmarried, living together
Length of time: __________

☐ Legally married
Length of time: __________

☐ Divorced
Length of time: __________

☐ Separated
Length of time: __________

☐ Widowed
Length of time: __________

☐ Annulment
Length of time: __________

Total number of marriages: ______

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

Parental Information

☐ Parents legally married

☐ Parents ever separated

☐ Parents ever divorced

☐ Mother remarried
No. times _____

☐ Father remarried
No. times _____

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

____

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Development

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No
If Yes, describe: ____
____
____
____
Has there been a history of child abuse? ☐ Yes ☐ No
If Yes, which type(s)? ☐ Sexual ☐ Physical ☐ Verbal ☐ Emotional
If Yes, the abuse was as a: ☐ Victim ☐ Perpetrator
Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ Other (please specify): _______________
Comments re: childhood development: ____
____
____

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? ☐ Yes ☐ No
If Yes, describe: ____
Currently or any history of being identified as a sexual perpetrator? ☐ Yes ☐ No
If Yes, describe: ____

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, describe: ____
Other cultural/ethnic information: ____

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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: ____

Legal

Current Status

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

If Yes, describe: ____

____

Are you presently on probation or parole? ☐ Yes ☐ No

If Yes, 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 complete the following:

Charges	Date	Where (city)	Results

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Education

Please fill in all that apply.

Years of education: ___________ Currently enrolled in school? ☐ Yes ☐ No

School Type	No. Years	Graduated?	Major
☐ High School/GED	___________	☐ Yes ☐ No	N/A
☐ Vocational	___________	☐ Yes ☐ No	___________
☐ College	___________	☐ Yes ☐ No	___________
☐ Graduate	___________	☐ Yes ☐ No	___________

Other Training: ___________

Special circumstances (e.g., learning disabilities, gifted): ___________

Employment

CURRENT EMPLOYMENT STATUS

☐ FT ☐ PT ☐ Temp ☐ Laid-off ☐ Disabled ☐ Retired ☐ Social Security ☐ Student

☐ Other, please describe: ___________

If employed, where: ___________ For how long? ___________

EMPLOYMENT HISTORY

Please list your job history, beginning with your most recent prior employer:

Employer	Dates	Title	Reasons Left	How Often Missed

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Military Experience

Military experience? ☐ Yes ☐ No

Combat experience? ☐ Yes ☐ No

Branch: ________________ Where served? ____

Date enlisted: ______________________________ Date discharged: ___________________________

Type of discharge: __________________________ Rank at discharge: _________________________

Leisure / Recreational

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

Activity	How often now?	How often in the past?

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Health History

PHYSICAL / MEDICAL HISTORY

- ☐ Alcoholism
- ☐ Abdominal pain
- ☐ Abortion
- ☐ Allergies
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Bed-wetting
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Colds/Coughs
- ☐ Constipation
- ☐ Chicken pox
- ☐ Dental problems
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Dizziness
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Ear infections
- ☐ Eating problems
- ☐ Fainting
- ☐ Fatigue
- ☐ Frequent urination
- ☐ Headaches
- ☐ Hearing problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Measles
- ☐ Measles
- ☐ Mumps
- ☐ Menstrual pain
- ☐ Miscarriages
- ☐ Neurological disorders
- ☐ Nausea
- ☐ Nose bleeds
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Sexually transmitted diseases
- ☐ Sleeping disorders
- ☐ Sore throat
- ☐ Scarlet fever
- ☐ Sinusitis
- ☐ Smallpox
- ☐ Stroke
- ☐ Sexual problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Toothache
- ☐ Thyroid problems
- ☐ Vision problems
- ☐ Vomiting
- ☐ Whooping cough

☐ Other, please describe:____

List any current health concerns: ____

List any recent health or physical changes: ____

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Health History (CONT.)

NUTRITION

Meal	How Often (Times per Week)	Typical Foods Eaten	Typical Amounts Eaten
Breakfast	______ / week	______________________	☐None ☐Low ☐Med ☐High
Lunch	______ / week	______________________	☐None ☐Low ☐Med ☐High
Dinner	______ / week	______________________	☐None ☐Low ☐Med ☐High
Snacks	______ / week	______________________	☐None ☐Low ☐Med ☐High

Comments: ____

____

MEDICATIONS

CURRENT PRESCRIBED MEDICATIONS	DOSE	DATES	PURPOSE	SIDE EFFECTS

CURRENT OVER-THE-COUNTER MEDICATIONS	DOSE	DATES	PURPOSE	SIDE EFFECTS

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

If Yes, describe: ____

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Health History (CONT.)

MOST RECENT EXAMINATIONS

Type of examination	Date (most recent visit)	Reason	Results
Last physical exam	______	______	______
Last doctor's visit	______	______	______
Last dental exam	______	______	______
Most recent surgery	______	______	______
Other surgery	______	______	______
Upcoming surgery	______	______	______

Family history of medical problems? ____

____

RECENT HEALTH CHANGES

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 ☐ Nervousness/tension

Describe changes in areas in which you checked above and when they began: ____________________

____

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Substance History

CHEMICAL USE HISTORY

Type of Substance	Method of Use & Amount	Frequency of Use	Age of First Use	Age of Last Use	Used in Last 48 Hours	Used in Last 30 Days
Alcohol	______	______	______	______	☐	☐
Barbiturates	______	______	______	______	☐	☐
Valium	______	______	______	______	☐	☐
Cocaine/Crack	______	______	______	______	☐	☐
Heroin /Opiates	______	______	______	______	☐	☐
Marijuana	______	______	______	______	☐	☐
PCP/LSD/Mescaline	______	______	______	______	☐	☐
Inhalants	______	______	______	______	☐	☐
Caffeine	______	______	______	______	☐	☐
Nicotine	______	______	______	______	☐	☐
Over the counter	______	______	______	______	☐	☐
Prescription drugs	______	______	______	______	☐	☐
Other drugs	______	______	______	______	☐	☐

Describe: ____

Substance of Preference:

1. ______________________ **2.** ______________________

3. ______________________ **4.** ______________________

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Substance History (CONT.)

SUBSTANCE USE QUESTIONS

Describe when and where you typically use substances: ____

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected your family or friends (include their perceptions of your use): ________

____

Reason(s) for use:

☐ Addicted ☐ Build confidence ☐ Escape ☐ Self-medication

☐ Socialization ☐ Taste ☐ Other (specify): ____________________________

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: ____

Have drugs or alcohol created a problem for your job? ☐ Yes ☐ No

If Yes, describe: ____

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Counseling / Prior Treatment History

Information about yourself (past and present):

		When	Where	Your Reaction to Overall Experience
Counseling/ Psychiatric Treatment	☐ Yes ☐ No	________	____________	______________________
Suicidal thoughts/attempts	☐ Yes ☐ No	________	____________	______________________
Drug/alcohol treatment	☐ Yes ☐ No	________	____________	______________________
Hospitalization (psychiatric)	☐ Yes ☐ No	________	____________	______________________
Involvement with self-help groups *	☐ Yes ☐ No	________	____________	______________________

Information about your significant other (past and present) or family member (describe): ________________

		When	Where	Your Reaction to Overall Experience
Counseling/ Psychiatric Treatment	☐ Yes ☐ No	________	____________	______________________
Suicidal thoughts/attempts	☐ Yes ☐ No	________	____________	______________________
Drug/alcohol treatment	☐ Yes ☐ No	________	____________	______________________
Hospitalization (psychiatric)	☐ Yes ☐ No	________	____________	______________________
Involvement with self-help groups *	☐ Yes ☐ No	________	____________	______________________

* *For example, AA, Al-Anon, NA, Overeaters Anonymous*

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Counseling / Prior Treatment History (CONT.)

Please check behaviors and symptoms that occur to you more often than 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
- ☐ Thoughts disorganized
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other (specify):

____

____

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

____

____

____

____

____

____

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Counseling / Prior Treatment History (CONT.)

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

____

____

____

____

____

____

What are your goals for therapy?

____

____

____

____

____

____

Do you feel suicidal at this time? ☐ Yes ☐ No

If Yes, explain: ____

____

____

____

____

____

____

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FOR STAFF USE

Therapist's comments: ____

____

____

____

____

Therapist's signature/credentials:______________________________ Date: _____/_____/_____

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