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Personal History Form—Adult (18+)

[PLEASE PRINT OR WRITE CLEARLY]

Client's name: __________________________Date of birth: ___________Age: ______ Date:_________

Gender: ___F ___M Address:_____________________________City: __________________State: ____

Zip: _________Phone (home): ______________(cell): ______________ (work): ____________ Ext:____

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

Reason for Referral

Current Problems, Symptoms and Situational Needs (check all that apply)

__ Sad/Depressed Mood
__Feelings of guilt/worthless
__Anxious/Nervous
__Phobia(s)
__Poor concentration
__Verbally abusive
__Substance use/abuse
__Loneliness
__ Antisocial behavior
__Gambling
__Poor self-care
__Disorganized Thoughts

__Weight loss/gain
__ Irritability
__Obsessive/compulsive
__Impulsivity
__Fidgety
__Physically assaultive
__Sexual acting out
__Memory Impairment
__ Avoiding People
__Heart Palpitations
__Suicidal Ideation
__Other mental health concerns (specify):_________________________

__Mood Swings
__Angry
__Panic Attacks
__Hyperactivity
__Hypersomnia (excessive sleeping)
__Lying
__Eating Disorder
__Sexual Addiction
__Cyber Addiction
__Hopelessness
__Hallucinations

__Tearful
__Elevated Mood
__Withdrawing
__Insomnia
__Stealing
__Poor Social Skills
__Sexual concerns
__ Disorientation
__Judgment Errors
__Appetite Change

____

Client Name: __________________________ DOB: ________________

Family/Social History

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

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

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No

Family History of Mental Illness, Substance Abuse, and Trauma

Is there a history of alcohol and drug problems in your family? _______Yes _______No

If Yes, describe: ____

Family history of mental health problems (e.g., ADHD, Depression, etc)? __Yes __No

If Yes, describe:____

Is there a history of violence in your family (i.e., pushing, hitting, threatening, etc.)? ___Yes ___No

Comments:____

Relationship Status (more than one answer may apply):

__ Single ___ Legally married ___Unmarried, living together ___Separated ___Divorce in process

__ Divorced ___Widowed ___ Annulment ___ Domestic Partnership

Total number of marriages: ____

Assessment of current relationship (if applicable): _______ Good ______Fair __________Poor

Parental Information

__ Parents legally married ___ Mother remarried: Number of times: ___

__ Parents have even been separated ___ Father remarried: Number of times: ____

__ Parents ever divorced

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

Client Name: __________________________ DOB: ________________

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 (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: ____

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: ____

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? ____ Yes ___ No

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: ____

Client Name: ___________________________ DOB: ________________

Past History

Traffic violations: ____ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___Yes ___ No Civil involvement: ___ Yes __ No

Comments About Above:____

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 disabilities, gifted): ______________________________

Employment

Begin with most recent job, list job history:

Employer	How Long	Title	Like Job?	How often miss work?
________________	____________	__________	_______________	_________________

Currently: ___ FT __ PT ___ Temp ___ Laid-off __ Disabled __ Retired

__ Social Security __ Student ___ Other (describe): _________________________________

Military

Military experience? _______ Yes _________________________ No Combat experience? _____ Yes __________________ No

Where: ____

Branch: ________________________________ Discharge date: __________________________

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?
_____________________________	_______________________	_______________________
_____________________________	_______________________	_______________________
_____________________________	_______________________	_______________________

Client Name: _________________________ DOB: _______________

Medical/Health (please check all that apply)

__ Alcoholism
__ Abdominal pain
__ Abortion
__ Allergies
__ Fainting
__ Appendicitis
__ Arthritis
__ Asthma
__ Hearing problems
__ Cancer
__ Chest pain
__ Chronic pain
__ Colds/Coughs
__ Constipation
__ Neurological disorders

___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Sore throat
___ Fatigue
___ Frequent urination
___ Headaches
___ Stroke
___ High blood pressure
___ Kidney problems
___ Measles
___ Thyroid problems
___ Vision problems
___Other (describe):_______________________________________

____ Pneumonia
____Vomiting
____ Sexually transmitted diseases
____ Sleeping disorders
____ Diarrhea
____ Scarlet Fever
____ Nausea
____ Diabetes
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Menstrual pain
____Miscarriages
____ Dizziness

List any current health concerns &/or recent health or physical changes: ____________________
____
____

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 doctor’s visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

____

Family history of medical problems: ____

Client Name: __________________________ DOB: ________________

____

Pleases 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: _________________________________

Nutrition

How would you describe your appetite over the past month?

____Excellent ____Good____Fair ____Poor

Have you gained or lost any weight recently? ____Yes ____No If Yes, How much?______________

Were you dieting? ____Yes ____No

Comments: .

Chemical Use History

If you have a history of substance use/abuse, please complete a ***Chemical Use Survey***-available upon request.

Do you smoke cigarettes? Y N Use smokeless tobacco? Y N

How would you describe your alcohol use?

Don’t drink Social drinker Daily drinker Alcoholic In Recovery

Tobacco: Frequency__________ Amount _________ Current No/Yes Last Use_________

Alcohol: Frequency__________ Amount _________ Current No/Yes Last Use_________

Caffeine: Frequency__________ Amount _________ Current No/Yes Last Use ________

Other: Frequency__________ Amount _________ Current No/Yes Last Use ________

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	____________	___________________	_____________
Suicidal thoughts/attempts	___	____	___________	___________________	_________________
Drug/alcohol treatment	__	____	____________	__________________	________________
Hospitalizations	____	____	____________	__________________	________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	____	____________________________		________________

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

____

____

Client Name: ___________________________ DOB: ________________

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

What are your goals for therapy? ____
____

Do you feel suicidal at this time? ______ Yes _______ No

If Yes, explain: ____
____

Do you have any history of self-injury or self-mutilation?_________________________________

If Yes, explain:____
____

Client Name: ___________________________ DOB: ________________