Personal History—Adult

Client's name:_____ Date: _____

Gender:____F_____M Date of birth:_____ Age: _____

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

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 ___Depression

___ Eating disorder ___Fear/phobias ___Mental confusion ___Sexual concerns

___ Sleeping problems ___Addictive behaviors ___Alcohol/drugs

___ Other mental health concerns (specify): _____

FAMILY INFORMATION

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

Significant others (e.g., brother, sisters, grandparents, steprelatives, half relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	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: _____

____Separated
Length of time: _____

____Divorced
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 have ever been separated

____ Parents ever divorced

____Mother remarried: Number of times: _____

____Father remarried: Number of times: _____

Special circumstances (e.g., 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 (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____ Friendly ____Leader ____Outgoing ____Shy/withdrawn ____Submissive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: _____

Any current or history of being as 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: _____

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: _____

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 disabilities, gifted): _____

EMPLOYMENT

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the 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:_____

Date drafted:_____ Type of discharge: _____

Date enlisted:_____ 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?

MEDICAL/PHYSICAL HEALTH

____ AIDS	____ Dizziness	____ Nose bleeds
____ Alcoholism	____ Drug abuse	____ Pneumonia
____ Abdominal pain	____ Epilepsy	____ Rheumatic fever
____ Abortion	____ Ear infections	____ Sexually transmitted diseases
____ Allergies	____ Eating problems	____ Sleeping disorders
____ Anemia	____ Fainting	____ Sore throat
____ Appendicitis	____ Fatigue	____ Scarlet fever
____ Arthritis	____ Frequent urination	____ Sinusitis
____ Asthma	____ Headaches	____ Smallpox
____ 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 (describe): _____
____ Diarrhea	____ Nausea	_____

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 doctor's visit			
Last dental exam			
Most recent surgery			
Other 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 ____Nervousness/tension

Describe changes in areas in which you checked above: _____

CHEMICAL USE HISTORY

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin /Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____

2. _____ 4. _____

SUBSTANCE ABUSE 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? (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: _____

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)	____	____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

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

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

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: _____

FOR STAFF USE

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

Therapist's comments: _____