Personal History Form—Adult (18+)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

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., brothers, sisters, grandparents, step-relatives, 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__ Friendly ___ Leader ___ Outgoing ___ Shy/withdrawn ___ Submissive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
___ 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
___ Mononucleosis
___ 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 (describe): _____

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 orfriends (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)	___	___	_____	_____	_____

Information about family/significant others (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
___ 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:_____

Any additional information that would assist us in understanding yourconcerns 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: ____/____/____

Supervisor's comments: _____

_____ Physical exam: ___ Required ___ Not required

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

(Certifies case assignment, level of care and need for exam)