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 following 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 __ Hyperactivity

__ Other mental health concerns (specify): _____

_____

Family Information

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

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

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

Marital Status (more than one answer may apply)

Single _____ Divorce in process ___ Divorced ___

Unmarried, living together ___ How long ___ Married ___ How long ___

Total number of marriages ___ Widowed ___

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.): _____

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

Comments on childhood: _____

_____

_____

_____

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__ Friendly __ Leader __ Outgoing __ Shy/withdrawn __ Submissive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: _____

Current Legal 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): _____

_____

Behaviors at school: _____

_____

Employment

Begin with most recent job, list job history:_____

Employer	Dates	Title	Reason left 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?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Support System

Please comment on your support system, who they are and how they are of help.

_____

_____

Medical/Physical Health

__ AIDS __ Dizziness __ Nose bleeds

__	Alcoholism	__	Drug abuse	__	Pneumonia
__	Abdominal pain	__	Epilepsy	__	Rheumatic Fever
__	Abortion	__	Ear infections	__	Scarlet Fever
__	Allergies	__	Eating problems	__	Sexual problems
__	Anemia	__	Fainting	__	Sexually transmitted diseases
__	Appendicitis	__	Fatigue	__	Sinusitis
__	Arthritis	__	Frequent urination	__	Sleeping disorders
__	Asthma	__	Headaches	__	Small Pox
__	Bed wetting	__	Hearing problems	__	Sore throat
__	Bronchitis	__	Hepatitis	__	Stroke
__	Cancer	__	High blood pressure	__	Thyroid problems
__	Chest Pain	__	Kidney problems	__	Tonsillitis
__	Chicken Pox	__	Measles	__	Toothache
__	Chronic pain	__	Menstrual pain	__	Tuberculosis
__	Colds/Coughs	__	Miscarriage	__	Vision problems
__	Constipation	__	Mononucleosis	__	Vomiting
__	Dental problems	__	Mumps	__	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

Current medications and Over the Count medications

Medication	Dose	Start Date	Purpose	Side effects

Are you allergic to any medications or drugs? ___Yes ___No

If Yes, describe: _____

Procedure	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other 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: _____

Substance Use History

Substance	Typical Amount Used	How Often	Age 1st Used	Last Time Used
Misuse of Prescription Medications				
Cocaine/Crack				
Heroin/Opiate				
Marijuana				
Alcohol				
LSD/Mescaline/PCP Ecstasy/Mushrooms				
Inhalants/Huffing				
Other Drugs_____				

Drug or Substance of Choice?

1. 3.
2. 4.

Substance Abuse Questions

Describe when and where you typically used substances:

_____
_____
_____
_____
_____

Describe any changes in your use patterns:

_____
_____

Reason(s) for use:

__ Addicted __ Build confidence __ Escape __ Other (specify)

__ Socialization __ Taste __ Self-medication __

How do you believe your substance use affects your life? _____

Have you ever been urged to cut down or stop by family and friends? Yes___ No ___

Have you felt annoyed or angry when someone comments on your drinking or substance abuse? Yes___ No ___

Have you felt guilty or regretted some of the things you've done while drinking or using substances? Yes___ No ___

Have you ever had a drink or use substances to get you going in the morning or steady your nerves? Yes___ No ___

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):

Service	When	Where	Experience
Counseling or Therapy			
Drug and Alcohol Treatment			
Psychiatric Medication Management			
AA, NA, other 12-step groups			
Other Self Help Groups			

Psychiatric Hospitalization			

Have you ever attempted suicide? ____Yes ____No Explain_____
Have you ever felt suicidal? ___ Yes ___ No Explain _____

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

__ Aggressive
__ Alcohol dependence
__ Anger
__ Antisocial behavior
__ Anxiety
__ Avoiding people
__ Chest pains
__ 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 your concerns or problems:

_____
_____
_____
_____

What are your goals for therapy or this evaluation?

_____
_____
_____
_____

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