PERSONAL HISTORY

In order to better serve you and your problems more fully, please fill out this **Personal History** form. This will take some time, but it will assist me to more quickly understand your situation. Also, this will enable me to have a more complete understanding of you as a person and the various aspects of your life. Please have this **Personal History** form completed before you come for your first appointment and bring it with you to that appointment. DO NOT MAIL IT TO ME. Feel free to use the back side if you need more space. You may find it helpful to fill this out with the assistance of a close friend or relative in order to recall this information most accurately. Thank you for taking the time. Your efforts will help me to help you.

Client Name:_____**Date:**_____

Client Date of Birth:_____**Gender:**_____**M** _____**F** **Age:**_____

Primary reason(s) for seeking services:

__Abuse __Anxiety __Fear/Phobias __Sleeping Problem
__Addictive behaviors __Attention/Hyperactivity __Mental Confusion __Suicidal Ideation
__Alcohol/Drugs __Coping __Panic Attacks __Sexual Concerns
__Anger Management __Depression __Relationship/Marital __Other_____

Current symptoms: (Please rate yourself and the intensity of symptoms you are currently experiencing.)

None = This symptom is not present at this time. **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning.
Moderate – Significant impact on quality of life and/or day-to-day functioning. **Severe** = Profound impact on quality of life and/or day-to-day functioning.

	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive behaviors	___	___	___	___	Internet addiction	___	___	___	___
Agitation	___	___	___	___	Irritability	___	___	___	___
Alcohol dependence	___	___	___	___	Judgment error	___	___	___	___
Anger	___	___	___	___	Laxative/diuretic abuse	___	___	___	___
Anorexia	___	___	___	___	Loneliness	___	___	___	___
Antisocial behavior	___	___	___	___	Loose associations	___	___	___	___
Anxiety	___	___	___	___	Medical problems	___	___	___	___
Appetite disturbance	___	___	___	___	Memory impairment	___	___	___	___
Attention/concentration	___	___	___	___	Mood swings	___	___	___	___
Bingeing/purging	___	___	___	___	Obsessions/compulsions	___	___	___	___
Chest pain/racing heart	___	___	___	___	Oppositional behavior	___	___	___	___
Circumstantial symptoms	___	___	___	___	Panic attacks	___	___	___	___
Conduct problems	___	___	___	___	Paranoid ideation	___	___	___	___
Delusions	___	___	___	___	Phobias/fears	___	___	___	___
Depressed mood	___	___	___	___	Physical trauma perpetrator	___	___	___	___
Disorientation	___	___	___	___	Physical trauma victim	___	___	___	___
Dissociative states	___	___	___	___	Poor grooming/hygiene	___	___	___	___
Distractibility	___	___	___	___	Psychomotor retardation	___	___	___	___
Drug dependence	___	___	___	___	Recurring thoughts	___	___	___	___
Eating disorder	___	___	___	___	Self-mutilation	___	___	___	___
Elevated mood	___	___	___	___	Sexual addiction	___	___	___	___
Elimination disturbance	___	___	___	___	Sexual dysfunction	___	___	___	___
Emotionality	___	___	___	___	Sexual trauma perpetrator	___	___	___	___
Emotional trauma perpetrator	___	___	___	___	Sexual trauma victim	___	___	___	___
Emotional trauma victim	___	___	___	___	Sick often	___	___	___	___
Fatigue/low energy	___	___	___	___	Sleep disturbance	___	___	___	___
Gambling	___	___	___	___	Social isolation	___	___	___	___
Grief	___	___	___	___	Substance abuse	___	___	___	___
Guilt	___	___	___	___	Suicidal thoughts	___	___	___	___
Hallucinations	___	___	___	___	Unclear thoughts	___	___	___	___
Hopelessness	___	___	___	___	Weight gain/loss	___	___	___	___
Hyperactivity	___	___	___	___	Worthlessness	___	___	___	___
Impulsivity	___	___	___	___	Worrying	___	___	___	___
					Other (specify)_____	___	___	___	___

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					

Current psychotropic medications	**Dose**	**Dates**	**Purpose**	**Side Effects**

Past psychotropic medications	**Dose**	**Dates**	**Purpose**	**Side Effects**

Name of psychiatrist: _____ **Location:** _____

Counseling/Prior Treatment History: (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					

Family Information:

Relationship	Name	Age	Living Yes	Living No	Living with You Yes	Living with You No
Father						
Mother						
Spouse						
Children						
Stepchildren						

Describe your relationship with your father (stepfather or adoptive father): _____

Describe your relationship with your mother (stepmother or adoptive mother): _____

Describe your relationship with your children (stepchildren): _____

Extended Family Information: (brothers, sisters, step or half-siblings) Please specify.

Relationship	Name	Age	Living Yes	Living No	Living with You Yes	Living with You No

Describe your relationship with your siblings: _____

Describe any past or current significant issues that you have with your family members: _____

Describe childhood family experience:

__outstanding home environment
__normal home environment
__chaotic home environment
__witnessed physical/verbal/sexual abuse toward others
__experienced physical/verbal/sexual abuse from others
__perpetrator of physical/verbal/sexual abuse toward others
__experienced neglect, inadequate nutrition

Age you left home_____ Circumstances:_____

Describe any special, unusual or traumatic circumstances that affected your development:_____

_____

_____

Relationship History:

Marital Status
__single, never married
__engaged for____months
__married for____years
__divorced for____years
__separated for____years
__divorce in process____months
__live-in for____years
____prior marriages (self)
____prior marriages (partner)

Intimate Relationship:
__never been in a serious relationship
__not currently in a relationship
__currently in a serious relationship

Relationship Satisfaction:
__very satisfied with relationship
__satisfied with relationship
__somewhat satisfied with relationship
__dissatisfied with relationship
__ very dissatisfied with relationship

Describe any past or current significant issues in intimate relationships:_____

_____

_____

Parent's Current Marital Status:

__married to each other
__separated for ____ years
__divorced for ____ years

__mother remarried ____ times
__father remarried ____ times
__mother involved with someone
__father involved with someone

__mother deceased for ____ years
(age of client at mother's death____)
__father deceased for ____ years
(age of client at father's death____)

Education:

Number of years of education:_____ Currently enrolled in school? _____No _____Yes/ Where?_____

__ High school graduate/GED

__ Vocational: Number of years:_____ Graduated: _____No _____Yes/Major_____

__ College: Number of years: _____Graduated: _____No _____Yes/Major_____

__ Graduate: Number of years: _____ Graduated: _____No _____Yes/Major_____

Other training:_____

Intellectual/academic functioning: (check all that apply)

__normal intelligence __high intelligence __underachieving __learning problems

__attention problems __authority conflict __mild/__moderate/__severe retardation

__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

Military:

Military experience __No__Yes Combat experience__No__Yes Branch_____ Served where_____

Medical/Physical Health:

__AIDS
__Alcoholism
__Abortion
__Allergies
__Anemia
__Arthritis/Rheumatism
__Cancer
__Chronic pain
__Diabetes
__Drug abuse
__Eating problems
__Epilepsy
__Fainting
__Fatigue
__Fibromyalgia
__Headaches
__Heart problems
__Hepatitis
__High blood pressure
__Irritable Bowel (IBS)
__Memory Loss
__Menstrual pain/irregularities
__Miscarriages
__Mononucleosis
__Nausea
__Neurological disorders
__Seizures
__Sexual problems
__Sexually Transmitted Diseases (STDs)
__Sleeping problems
__Stroke
__Thyroid problems

Current prescribed medications	Dose	Dates	Purpose	Side Effects

Current over-the-counter medications	Dose	Dates	Purpose	Side Effects

Name of primary care physician: _____ **Location:** _____

Substance Use/Abuse History: (Information about client past and present.)

	Current use	Frequency	Amount
__Alcohol			
__Amphetamine/speed			
__Barbiturates			
__Caffeine			
__Cocaine/Crack			
__Heroin/Opiates			
__Inhalants			
__LSD/PCP/Mescaline			
__Marijuana/hashish			
__Nicotine/cigarettes			
__Prescription drugs			

Substance use status:

__no history of abuse __active abuse __early full remission __early partial remission __sustained full remission __sustained partial remission

Treatment history:

__outpatient (age____) __inpatient (age____) __ 12-step program (age____) __ stopped on my own (age____) __other (age____)_____

Consequences of substance abuse: (Check all that apply)

__arrests	__hangovers	__overdose	__suicidal impulse
__assaults	__job loss	__relationship conflicts	__tolerance changes
__binges	__loss of control/amount used	__seizures	__withdrawal symptoms
__blackouts	__medical conditions	__sleep disturbance	__other_____

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

_____

_____

Reasons for use:

__Addicted	__Escape	__Socialization	
__Build confidence	__Self-medicate	__Taste	__Other (specify):_____

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

_____

Substance Use/Abuse History: (Information about family past and present)

Does/has anyone in your family present/past have/had a problem with drugs or alcohol?_____

_____

_____

Does/has anyone in your family present/past have/had treatment for substance use or abuse?_____

_____

_____

Legal: Current Status

Are you involved in any active legal cases (traffic, civil, criminal, DHS)? _____No _____Yes

If yes, describe and indicate the court and hearing/trial dates and charges:_____

_____

Are you presently on probation or parole? _____No _____Yes

If yes, describe:_____

Legal: Past History

Traffic violations: _____No _____Yes DWI/DUI: _____No _____Yes DHS: _____No _____Yes

Criminal involvement: _____No _____Yes

If you responded **Yes** to any of the above, please provide the following information:

Charges	Date	Where (city)	Results

Financial:

Are you currently under financial stress? _____No _____Yes If yes, describe:_____

Do you spend impulsively? _____No _____Yes If yes, describe:_____

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 dysfunction?_____No_____Yes If yes, describe:_____

History of sexual perpetration?_____No_____Yes 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? _____No _____Yes

If yes, describe:_____

Other cultural/ethnic information:_____

Spiritual/Religious:

How important to you are spiritual matters? _____None _____Little _____Moderate _____Much

Are you affiliated with a spiritual or religious group? _____No _____Yes If yes, describe:_____

Were you raised within a spiritual or religious group? _____No _____Yes If yes, describe:_____

Would you like your spiritual/religious beliefs incorporated into the counseling? _____No _____Yes

If yes, describe:_____

Leisure/Recreational:

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

Activity	How often now?	How often in the past?

Treatment Hopes and Desires:

If you could have three wishes, what would they be?_____

What do you consider to be your strengths and weaknesses?_____

What are your future goals?_____

Is there any other information you wish to share that would be helpful in understanding your concerns and situation? _____