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Personal History (Adult) for: _____ Date of Birth:_____Date: _____ Case #: ____

(Please Print Your Name)

If you need more space for any of the questions please use additional sheets.

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): _____

Counseling/Prior Treatment History Information about client (past and present):

	Yes	No	When	With Whom/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 & symptoms that occur to you more often than you would prefer them to:

___ 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 before mentioned 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: _____

Family Information

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

Marital Status (more than one answer may apply)

___ Single ____ Divorce in process ____ Unmarried, living together

Length of time: _____ Length of time: _____

___ Legally married ____ Separated ____ Divorced

Length of time: _____ Length of time: _____ Length of time: _____

___ Widowed ____ Annulment

Length of time: _____ Length of time: _____ 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 ever 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
_____ Other (please specify): _____

Comments re: childhood development: _____

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: _____

_____

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 behavior or history of being a sexual perpetrator? ____ 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: _____

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

Employment – List 3 most recent jobs

Employer	Dates	Title	Reason left the job	How often miss work?

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

__ Social Security __ Student ____ Other (describe): _____

Level of Education

____ High School/GED ____ Vocational ___ Years of College Did you graduate? Yes No

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ____ No

Leisure/Recreational

Describe special areas of interest or hobbies: _____

_____

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 recent health or physical changes/concerns: _____

_____

Current Physician: _____ Phone: _____

Nutrition & Exercise

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

Behaviors tied to food (restriction, binge/purge, emotional reactions): _____

_____

Exercise Habits: _____

Current prescribed medications	Dose	Frequency	Purpose	Side effects

Prescribing Physician(s): _____

Current over-the-counter meds	Dose	Frequency	Purpose	Side effects

Are you allergic to any medications or drugs? ___ Yes __ No If Yes, describe: _____

Current Vitamins/Herb Supplements	Dose	Frequency	Purpose	Side effects

Alternative Therapies: _____

_____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery or Pending			

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 substance 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: _____