Inner Strength Counseling
Eleanor Salemi, LCSW

Personal History—Adult (18+)

Client's name: _____ Date: _____

Gender: ____ F ____ M Date of birth: _____ Age: _____ SS: _____

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

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

Phone (Home): _____ (Cell:) _____ Okay to leave message? Yes: ____ No: ____

(Work): _____ Ext: _____ email: _____

EMERGENCY INFORMATION

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
Address _____ City _____ State _____ Zip _____
Physician _____ Phone _____
Address _____ City _____ State _____ Zip _____
Psychiatrist _____ Phone _____
Address _____ City _____ State _____ Zip _____
Other Physicians _____ Phone _____
Current Medications _____
Allergies _____

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 concerns (specify): _____

FAMILY INFORMATION

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No	Quality of relationship with you		
Mother	_____	____	____	____	____	____	____ good	____ fair	____ poor
Father	_____	____	____	____	____	____	____ good	____ fair	____ poor
Spouse	_____	____	____	____	____	____	____ good	____ fair	____ poor
Children	_____	____	____	____	____	____	____ good	____ fair	____ poor
	_____	____	____	____	____	____	____ good	____ fair	____ poor
	_____	____	____	____	____	____	____ good	____ fair	____ poor

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

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No	Quality of relationship with you		
_____	_____	____	____	____	____	____	____ good	____ fair	____ poor
_____	_____	____	____	____	____	____	____ good	____ fair	____ poor
_____	_____	____	____	____	____	____	____ good	____ fair	____ poor
_____	_____	____	____	____	____	____	____ good	____ fair	____ poor
_____	_____	____	____	____	____	____	____ good	____ fair	____ poor
_____	_____	____	____	____	____	____	____ good	____ fair	____ poor

Marital Status:

____ Single____ Unmarried, living together____ Married____ Separated ____ Divorced____ Widowed

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

PARENTAL INFORMATION

____ Parents legally married

____ Parents have never been separated

____ Parents never 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 a 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
____ 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
____ 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

____ 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	Reason	With Whom	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	Reason	With Whom	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
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ 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:

List your strengths

List areas you feel you need to develop

What do you like most about yourself?

What are some ways you cope with obstacles and stress?

What are your goals for therapy? What would you like to accomplish?

Any additional information that would assist us in understanding your concerns or problems:

Do you feel suicidal at this time? ____ Yes ____ No

If yes, explain:

Therapist's signature/credentials: _____ Date: _____