

**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): \_\_\_\_\_ (Mobile:) \_\_\_\_\_ 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 \_\_\_\_\_

Psychiatrist \_\_\_\_\_ 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		Living with you		Quality of relationship					
			Yes	No	Yes	No	with you					
Mother	_____	___	___	___	___	___	___	good	___	fair	___	poor
Father	_____	___	___	___	___	___	___	good	___	fair	___	poor
Spouse	_____	___	___	___	___	___	___	good	___	fair	___	poor
Children	_____	___	___	___	___	___	___	good	___	fair	___	poor
	_____	___	___	___	___	___	___	good	___	fair	___	poor
	_____	___	___	___	___	___	___	good	___	fair	___	poor

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

Relationship	Name	Age	Living		Living with you		Quality of relationship							
			Yes	No	Yes	No	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 \_\_\_ Mother remarried: Number of times: \_\_\_\_\_  
\_\_\_ Parents have never been separated \_\_\_ Father remarried: Number of times: \_\_\_\_\_  
\_\_\_ Parents never 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: \_\_\_ Survivor \_\_\_ 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.

<u>Charges</u>	<u>Date</u>	<u>Where (city)</u>	<u>Results</u>
----------------	-------------	---------------------	----------------

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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            | ___ Dizziness              | ___ Nose bleeds                   |
| ___ Alcoholism      | ___ Drug abuse             | ___ Pneumonia                     |
| ___ Abdominal pain  | ___ Epilepsy               | ___ Rheumatic fever               |
| ___ Abortion        | ___ Ear infections         | ___ Sexually transmitted diseases |
| ___ Allergies       | ___ Eating problems        | ___ Sleeping disorders            |
| ___ Anemia          | ___ Fainting               | ___ Sore throat                   |
| ___ Appendicitis    | ___ Fatigue                | ___ Scarlet fever                 |
| ___ Arthritis       | ___ Frequent urination     | ___ Sinusitis                     |
| ___ Asthma          | ___ Headaches              | ___ Smallpox                      |
| ___ Bronchitis      | ___ Hearing problems       | ___ Stroke                        |
| ___ Bed-wetting     | ___ Hepatitis              | ___ Sexual problems               |
| ___ Cancer          | ___ High blood pressure    | ___ Tonsillitis                   |
| ___ Chest pain      | ___ Kidney problems        | ___ Tuberculosis                  |
| ___ Chronic pain    | ___ Measles                | ___ Toothache                     |
| ___ Colds/Coughs    | ___ Mononucleosis          | ___ Thyroid problems              |
| ___ Constipation    | ___ Mumps                  | ___ Vision problems               |
| ___ Chicken pox     | ___ Menstrual pain         | ___ Vomiting                      |
| ___ Dental problems | ___ Miscarriages           | ___ Whooping cough                |
| ___ Diabetes        | ___ Neurological disorders | ___ Other (describe): _____       |
| ___ Diarrhea        | ___ Nausea                 | _____                             |

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List any current health concerns: \_\_\_\_\_

List any recent health or physical changes: \_\_\_\_\_

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): \_\_\_\_\_

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          | ____ Elevated mood       | ____ Phobias/fears          |
| ____ Alcohol dependence  | ____ Fatigue             | ____ Recurring thoughts     |
| ____ Anger               | ____ Gambling            | ____ Sexual addiction       |
| ____ Antisocial behavior | ____ Hallucinations      | ____ Sexual difficulties    |
| ____ Anxiety             | ____ Heart palpitations  | ____ Sick often             |
| ____ Avoiding people     | ____ High blood pressure | ____ Sleeping problems      |
| ____ Chest pain          | ____ Hopelessness        | ____ Speech problems        |
| ____ Cyber addiction     | ____ Impulsivity         | ____ Suicidal thoughts      |
| ____ Depression          | ____ Irritability        | ____ Thoughts disorganized  |
| ____ Disorientation      | ____ Judgment errors     | ____ Trembling              |
| ____ Distractibility     | ____ Loneliness          | ____ Withdrawing            |
| ____ Dizziness           | ____ Memory impairment   | ____ Worrying               |
| ____ Drug dependence     | ____ Mood shifts         | ____ Other (specify): _____ |
| ____ Eating disorder     | ____ Panic attacks       | _____                       |

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Briefly discuss how the above symptoms impair your ability to function effectively:

List your strengths

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: \_\_\_\_\_