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
Aggressive behaviors	___	___	___	___
Agitation	___	___	___	___
Alcohol dependence	___	___	___	___
Anger	___	___	___	___
Anorexia	___	___	___	___
Antisocial behavior	___	___	___	___
Anxiety	___	___	___	___
Appetite disturbance	___	___	___	___
Attention/concentration	___	___	___	___
Bingeing/purging	___	___	___	___
Chest pain/racing heart	___	___	___	___
Circumstantial symptoms	___	___	___	___
Conduct problems	___	___	___	___
Delusions	___	___	___	___
Depressed mood	___	___	___	___
Disorientation	___	___	___	___
Dissociative states	___	___	___	___
Distractibility	___	___	___	___
Drug dependence	___	___	___	___
Eating disorder	___	___	___	___
Elevated mood	___	___	___	___
Elimination disturbance	___	___	___	___
Emotionality	___	___	___	___
Emotional trauma perpetrator	___	___	___	___
Emotional trauma victim	___	___	___	___
Fatigue/low energy	___	___	___	___
Gambling	___	___	___	___
Grief	___	___	___	___
Guilt	___	___	___	___
Hallucinations	___	___	___	___
Hopelessness	___	___	___	___
Hyperactivity	___	___	___	___
Impulsivity	___	___	___	___

	None	Mild	Moderate	Severe
Internet addiction	___	___	___	___
Irritability	___	___	___	___
Judgment error	___	___	___	___
Laxative/diuretic abuse	___	___	___	___
Loneliness	___	___	___	___
Loose associations	___	___	___	___
Medical problems	___	___	___	___
Memory impairment	___	___	___	___
Mood swings	___	___	___	___
Obsessions/compulsions	___	___	___	___
Oppositional behavior	___	___	___	___
Panic attacks	___	___	___	___
Paranoid ideation	___	___	___	___
Phobias/fears	___	___	___	___
Physical trauma perpetrator	___	___	___	___
Physical trauma victim	___	___	___	___
Poor grooming/hygiene	___	___	___	___
Psychomotor retardation	___	___	___	___
Recurring thoughts	___	___	___	___
Self-mutilation	___	___	___	___
Sexual addiction	___	___	___	___
Sexual dysfunction	___	___	___	___
Sexual trauma perpetrator	___	___	___	___
Sexual trauma victim	___	___	___	___
Sick often	___	___	___	___
Sleep disturbance	___	___	___	___
Social isolation	___	___	___	___
Substance abuse	___	___	___	___
Suicidal thoughts	___	___	___	___
Unclear thoughts	___	___	___	___
Weight gain/loss	___	___	___	___
Worthlessness	___	___	___	___
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? ________________