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Adult Personal History

Please complete this form in its entirety and bring it to your initial consultation. Of course, it is confidential and will not be discussed or distributed without your written permission. If you have questions about any of the content of this form, please note them and we can discuss them in our meeting.

Name: _____ Today's Date: _____

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

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

Phone (home): _____ (work): _____ (cell): _____

Family Information

| Relationship | Name | Age | Living | | Living with you | |
|--------------|-------|-------|--------|-------|-----------------|-------|
| | | | Yes | No | Yes | No |
| Mother | _____ | _____ | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ | _____ | _____ | _____ |
| Children | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ | _____ | _____ |

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

| Relationship | Name | Age | Living | | Living with you | |
|--------------|-------|-------|--------|-------|-----------------|-------|
| | | | Yes | No | Yes | No |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ | _____ |

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 married Mother remarried: Number of times: _____
 Parents have been separated Father remarried: Number of times: _____
 Parents ever divorced Your age at the time of their divorce

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: _____

Were you abused as a child? Yes No
If Yes, please describe _____

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 as sexual perpetrator? Yes No

If Yes, describe: _____

Cultural/Ethnic

With which cultural or ethnic group do you identify? _____

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 graduate/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 for leaving | How often miss work? |
|----------|-------|-------|--------------------|----------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Currently: FT PT Temp Laid-off Disabled Retired Student Other

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 | ___ Small Pox |
| _____ 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 | _____ |

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: _____ Some days I have no appetite.

| | | | | |
|--------------------------------|------|-------|---------|--------------|
| 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 | | | | Used in last |
|--------------------|-----------------------------|---------------------|---------------------|--------------------|--------------|-------|---------|-------|--------------|
| | | | | | 48 hours | | 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 uses 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 | Where | Benefit |
|-----------------------------|-------|-------|-------|-------|---------|
| Counseling/Psychiatric care | _____ | _____ | _____ | _____ | _____ |
| Suicidal thoughts/attempts | _____ | _____ | _____ | _____ | _____ |
| Drug/alcohol treatment | _____ | _____ | _____ | _____ | _____ |
| Hospitalizations | _____ | _____ | _____ | _____ | _____ |
| Self-help Groups | _____ | _____ | _____ | _____ | _____ |

Information about family/significant others (past and present):

| | Yes | No | When | Where | Benefit |
|-----------------------------|-----|-----|-------|-------|---------|
| Counseling/Psychiatric care | ___ | ___ | _____ | _____ | _____ |
| Suicidal thoughts/attempts | ___ | ___ | _____ | _____ | _____ |
| Drug/alcohol treatment | ___ | ___ | _____ | _____ | _____ |
| Hospitalizations | ___ | ___ | _____ | _____ | _____ |
| Self-help groups | ___ | ___ | _____ | _____ | _____ |

Primary reason(s) for seeking my services:

| | | | |
|---|-----------------------|----------------------|---------------------|
| _____ Anger management | ___ Anxiety | ___ Coping | ___ Depression |
| _____ Eating disorder | ___ Fear/phobias | ___ Mental confusion | ___ Sexual concerns |
| _____ Sleeping problems | ___ Suicidal feelings | ___ Alcohol/drugs | |
| _____ Other mental health concerns (specify): _____ | | | |

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 _____

Briefly discuss how the above 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? _____

Other Concerns

Are there any other concerns that this history failed to address that may aide me in understanding you and why you sought my psychological care?