Michael Edward Tansy, Ph.D., ABPP
Psychologist
Fellow, American Psychological Association
Specialist, American Board of Professional Psychology
4140 East Baseline Road, Suite 101 Mesa, AZ 85206
Telephone: (480) 966-9337 Fax: (480) 704-5181 Email: drtansy@michaeltansy.com

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

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

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

			Living		Living with you	
Relationship	Name	Age	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: _____

_____

Pleases 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		Used in last
					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?