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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): _____

Emergency Contact: Name _____ (cell) _____ (email) _____

## 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 |

| | | | | | | |
|---|---|---|---|---|---|---|
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**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 | ____ Sleep disorder |
| _____ 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 | |
|---|---|---|---|---|---|---|---|---|
| | | | | | 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 | ___ | ___ | _____ | _____ | _____ |
| 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?