

# Personal History Form

## Personal Information

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

OK to send mail? \_\_\_\_\_ If no, please provide alternate address. \_\_\_\_\_

Home phone \_\_\_\_\_ OK to leave a message? \_\_\_\_\_

Cell phone \_\_\_\_\_ OK to leave a message? \_\_\_\_\_

Work phone \_\_\_\_\_ OK to leave a message? \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relationship to you \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Work Phone \_\_\_\_\_

Referral Source (how you heard about counseling services) \_\_\_\_\_

## Health Information

Please answer the following questions using the following scale

*5 = Excellent 4 = Good 3 = Average 2 = Poor 1 = Failing*

How would you currently rate your physical health? \_\_\_\_\_

How would you currently rate your mental health? \_\_\_\_\_

How would you currently rate your spiritual health? \_\_\_\_\_ (If does this does not apply to you, please use N/A.)

Please list current symptoms (reason you are here) and circle those you currently find most bothersome. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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## Medical Information

Do you now have, or have you had in the past, any of the following? Check all that apply.

Asthma		Allergies		Headaches	
Brain Injury		Epilepsy		Seizures	
Digestive Disorders		Cancer		Diabetes	
Breathing Problems		Immune System Problems		Heart Disease	
High Blood Pressure		Vision Problems		Hearing Problems	
Arthritis		Urinary Disorders		Tuberculosis	
Thyroid Disorder		Multiple Sclerosis		Chronic Fatigue Syndrome	
Fibromyalgia		Pregnancy (how many)		Miscarriage (how many)	
Abortion (how many)		Sexually Transmitted Disease		Sleep Disorder	
Serious Accident		Surgery		Other	

Are you currently under the care of a Doctor or other medical health professional? \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Name of Specialist Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Please list any prescription or medications you are currently taking. \_\_\_\_\_

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Please list any over the counter medications, vitamins, or herbal supplements you are currently taking. \_\_\_\_\_

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Do you currently exercise? \_\_\_\_\_ If yes, please indicate how many times per week. \_\_\_\_\_

# Personal History Form

Please indicate substances currently used (over the past 6 months), how much at one time, how many times per day/week, age of first use, past use history, and length of time used.

Substance	Current Usage			Age first used	Past Usage	
	Currently Use (Y/N)	Amount used at one time	Frequency (times per day/week)		Last used (Mo/Yr)	Length of time used
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Ecstasy						
Cocaine/Crack						
Heroin						
Methamphetamines						
PCP/LSD/Mushrooms						
Pain Killers						
Steroids						
Tranquilizers						
Sleeping Pills						
Diet Pills						

Have you ever believed your substance use was a problem for you? \_\_\_\_\_

Has anyone ever told you they believed your substance use was a problem? \_\_\_\_\_

Have you ever had withdrawal symptoms when trying to stop using any substances? \_\_\_\_\_

Have you ever had problems with work, relationships, health, the law, etc. due to your substance use? If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

Have you ever participated in drug and alcohol treatment? \_\_\_\_\_ If yes, please list type, length, dates, and age at time you received these services. \_\_\_\_\_

\_\_\_\_\_

Do you currently or have you ever attended Alcoholics or Narcotics Anonymous? \_\_\_\_\_ If yes, please list length of time sober and number of meetings you attend per week. \_\_\_\_\_

\_\_\_\_\_

# Personal History Form

## Mental Health Information

Have you ever been in counseling/therapy before? \_\_\_\_\_ If yes did you find it helpful or effective? \_\_\_\_\_

Are you currently receiving mental health services? \_\_\_\_\_ If yes, please list name of practitioner and type of services you are receiving. \_\_\_\_\_

Have you ever been hospitalized for mental health concerns? \_\_\_\_\_ If yes, list date(s) and length of stay. \_\_\_\_\_

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed. \_\_\_\_\_

Has anyone in your family ever been diagnosed with a mental illness? \_\_\_\_\_ If yes, please list relationship(s) and illness(es). \_\_\_\_\_

Have you ever or are you currently engaging in self harm? Currently? \_\_\_\_\_ Past? \_\_\_\_\_

Have you ever or are you currently contemplating suicide? Currently? \_\_\_\_\_ Past? \_\_\_\_\_

Have you ever or are you currently contemplating harming another person? \_\_\_\_\_

Currently? \_\_\_\_\_ Past? \_\_\_\_\_

Have you ever attempted suicide? \_\_\_\_\_ If yes please list date(s), method(s), and your age at time of attempt. \_\_\_\_\_

Has anyone in your family ever attempted suicide? \_\_\_\_\_ If yes list relationship. \_\_\_\_\_

Has anyone in your family ever completed suicide? \_\_\_\_\_ If yes list relationship. \_\_\_\_\_

Has anyone else in your life ever attempted? \_\_\_\_\_ or completed suicide? \_\_\_\_\_

Relationship \_\_\_\_\_

Do you currently or have you ever had trouble sleeping? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

# Personal History Form

Do you currently or have you ever had problems with eating or with food? \_\_\_\_\_ If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

Briefly describe why you are coming in for counseling and the goals you hope to achieve in therapy. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Spiritual Information**

Have you ever or do you currently engage in a personal faith practice? \_\_\_\_\_ If yes please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever, or do you currently belong to a faith community (church, synagogue, temple, religious order, etc.)? \_\_\_\_\_ If yes, please describe your current level of connection and involvement. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you want to incorporate your faith/spirituality into the counseling process? \_\_\_\_\_ If yes, please describe how you would like to do so, and if you are specifically seeking spiritual guidance or direction. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Personal History Form

## Relationship Information

Are you currently in a relationship? \_\_\_\_\_ If yes, please list status. \_\_\_\_\_

Name of Person \_\_\_\_\_ Length of time you have known each other \_\_\_\_\_

Length of time you have been together \_\_\_\_\_ Do you currently live together? \_\_\_\_\_

Number of marriages \_\_\_\_\_ Number of divorces \_\_\_\_\_ If widowed, your age at death of Spouse. \_\_\_\_\_

Do you have children? \_\_\_\_\_ If yes, please list below.

Name	Age	Lives with you	Name	Age	Lives with you

If you are coming in for Couples or Family counseling, or are currently experiencing relationship difficulties, would you like to address in individual counseling? Please briefly describe. \_\_\_\_\_

\_\_\_\_\_

Other persons living in your household and your relationship to them. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Personal History Form

## Family Information

Were you adopted? \_\_\_\_\_ If yes, your age at time of adoption. \_\_\_\_\_

With whom did you live until the age of 18? \_\_\_\_\_

Did your parents ever divorce? \_\_\_\_\_ If yes, your age at time of divorce. \_\_\_\_\_

If divorced, did your parents ever re-marry? \_\_\_\_\_ If yes, list parent(s) and your age(s) at time of remarriage \_\_\_\_\_

Were you ever in foster care or residential care? \_\_\_\_\_ If yes, please list age and living situation

\_\_\_\_\_

\_\_\_\_\_

Mother's current age \_\_\_\_\_ If deceased, age at death \_\_\_\_\_ Your age at time of her death \_\_\_\_\_

Father's current age \_\_\_\_\_ If deceased, age at death \_\_\_\_\_ Your age at time of his death \_\_\_\_\_

Do you have siblings? \_\_\_\_\_ If yes, list names, ages, and relationship. \_\_\_\_\_

\_\_\_\_\_

Have you ever experienced the death of a family member or a close friend? \_\_\_\_\_ If yes, please list relationship and your age at time of their death. \_\_\_\_\_

Please indicate if you or a member of your immediate family experienced any of the following. If a family member, please indicate relationship(s).

Event	Self	Other	Relationship	Event	Self	Other	Relationship
Emotional Abuse				Legal Problems			
Physical Abuse				Frequent/Multiple Moves			
Sexual Abuse				Homelessness			
Domestic Violence				Financial Problems			
Neglect				Lived over-seas			
Substance Abuse				Military member			
Serious Illness				Discrimination			
Accident or Injury				Other			

# Personal History Form

## Educational Information

Number of years of education completed \_\_\_\_\_

Degree(s) achieved (please mark all that apply)

High School Diploma	<input type="checkbox"/>	G.E.D.	<input type="checkbox"/>	Vocational/Trade School Certificate	<input type="checkbox"/>	Associates Degree	<input type="checkbox"/>
Bachelors Degree	<input type="checkbox"/>	Masters Degree	<input type="checkbox"/>	Doctorate Degree	<input type="checkbox"/>	Other	<input type="checkbox"/>

## Vocational Information

Are you currently employed? \_\_\_\_\_ If yes, please list position title, name of employer, type of work, and length of time at employment. \_\_\_\_\_

If you are not currently working, how long have you been un-employed? \_\_\_\_\_

What types of jobs have you typically held? \_\_\_\_\_

What is the longest period of time you have ever worked at one job? \_\_\_\_\_

Are you currently considering a change in job or career? \_\_\_\_\_ If yes, what type of work are you interested in doing? \_\_\_\_\_

## Military Information

Have you ever served in the military? \_\_\_\_\_ If yes, please list branch, rank, and current status (active/discharged) \_\_\_\_\_

If deployed please list dates and family/relationship status pre and post deployment \_\_\_\_\_



# Personal History Form

## Hobbies/Interests

Please list your personal hobbies and interests \_\_\_\_\_

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## Legal Information

Have you ever been the victim of a crime? \_\_\_\_\_ If yes, please list date and briefly describe.

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Are you currently involved in divorce or child custody proceedings? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

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Have you ever been convicted of a misdemeanor or felony? \_\_\_\_\_ If yes, please explain.

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