PERSONAL HISTORY FORM

I. DEMOGRAPHIC INFORMATION

Client's Name ____ Date ____________

Gender ______M______F Date of Birth ___________ Age _______

Address ____________________ City _________________ State _____ Zip ________

Phone (Home) _________________ (Work) ___________________ (Cell) ________________

Referral Source _________________________ Payment Source _____________________

What is the best way to contact you? ____

Is it okay to contact you at home? ____

II. PRESENTING PROBLEMS

What prompted you to seek treatment? ____

____

How long has this been a problem for you? ____

How would you rate the severity of the problem today? __Mild __Moderate __Serious __Severe

How would you rate the severity of the problem 1 month ago? __Mild __Moderate __Serious __Severe

What specific symptoms/problems do you think are relevant to your treatment? Please check all that apply.

__ Aggressive behaviors
__ Angry outbursts
__ Crying easily
__ Trouble concentrating
__ Fatigue or loss of energy
__ Depressed mood
__ Feelings of worthlessness
__ Thoughts of hurting yourself or others
__ Nightmares
__ Sleep disturbances
__ Relationship problems (peers or family)
__ Financial stress
__ Academic problems
__ Odd behaviors or thoughts
__ Taking alcohol/drugs
__ Difficulty following directions
__ Abusive relationships
__ Recent weight change
__ Fears/phobias
__ Coping problems
__ Legal problems
__ Social withdrawal
__ Distrust
__ Rapid heart rate
__ Restlessness
__ Recent traumatic events
__ Unresolved childhood issues
__ Chest pains
__ Increased illnesses or medical problems
__ Dizziness or lightheadedness
__ Stomach problems
__ Sweating
__ Grief or loss issues
__ Parenting problems

FAMILY INFORMATION

Family Information

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

Significant Others (Brothers, Sisters, 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
Length of time _____

_____ Unmarried, living together
Length of time _____

_____ Legally married
Length of time _____

_____ Separated
Length of time _____

_____ Divorced/(number of times)
Length of time _____/_____

_____ Widowed
Length of time _____

_____ Annulment
Length of time _____

Total number of marriages _____

Assessment of Current Relationship (if applicable) ____ Good ___ Fair ___Poor
Please explain: ____

____

Parental Information

_____ Parents legally married
_____ Parents have ever been separated
_____ Parents ever divorced

_____ Mother remarried: Number of times _____
_____ Father remarried: Number of times _____

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)

____

____

____

Strengths/support ____
Stressors/problems ____

DEVELOPMENT

Have you ever been abused as a child or an adult? _____ No _____ Yes
If yes, which types of abuse? _____ Sexual _____ Physical _____ Verbal _____ Perpetrator _____ Victim
If yes, was the abuse ever reported? _____ No _____ Yes

Other childhood issues: ___ Neglect ___ Inadequate Nutrition ___ Medical Complications
Comments regarding childhood experiences: ____

____
____
____
____

SOCIAL RELATIONSHIPS

Check how you generally interact with friends and family members: (check all that apply)
_____ Lovingly _____ Fight/Argue _____ Get picked on _____ Try to avoid them
Other (specify) ____

How would you describe your personality? (check all that apply)
_____ Follower _____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn

Do you have a best friend now? _____ No _____ Yes In the past? _____ No _____ Yes

Sexual Orientation: ____________________ Comments: ________________________________

Strengths/support ____
Stressors/problems ____

CULTURAL / ETHNIC

From which cultural or ethnic group, if any, do you belong? __________________________
Are you experiencing any problems due to cultural or ethnic issues? _____ No _____ Yes (describe) __________

____

Other cultural / ethnic information: ____

____

Strengths/support ____
Stressors/problems ____

SPIRITUAL / RELIGIOUS

How important to you are spiritual matters? _____ Not _____ Little _____ Moderate _____ Much
Are you affiliated with a spiritual or religious group? ______________________________
Were you raised within a spiritual or religious group? _____ No _____ Yes (describe) __________________
Would you like your spiritual/religious beliefs incorporated into the counseling?
_____ No _____ Yes (describe)____

Strengths/support ____
Stressors/problems ____

LEGAL

List all arrests (charges), dates of arrests, and the outcomes
____
____
____

Please describe any past or present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling, etc.) ____

Strengths/support ____
Stressors/problems ____

EDUCATIONAL

(CHILD/TEEN)
What grade are you in? __________ What school do you attend? ______________________
Academic Grades: *above average, average, below average, inconsistent*
Are you in Special Education Classes? _____ No _____ Yes (describe) ______________________
Have you ever failed a grade? _____ No _____ Yes Which one(s)? ______________________
How many schools have you attended? __________

(ADULT)
Graduated from High School/GED? _____ No _____ Yes Year Completed? __________
College: __________ Major: __________ Year Completed? __________
Are you satisfied with your level of education? Explain: ______________________
____
Strengths/support ____
Stressors/problems ____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left the Job	How often miss work?

Strengths/support ____
Stressors/problems ____

MILITARY

Military Experience? _____ No _____ Yes Combat History? _____ No _____ Yes
Branch __________ Discharge Date __________ Date Drafted __________ Type of Discharge __________ Date Enlisted __________ Rank at Discharge __________

Strengths/support ____
Stressors/problems ____

LEISURE / RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, church activities, diet/health, fishing, traveling, etc.)
____
____

Strengths/support ______________________________
Stressors/problems ______________________________

MEDICAL / PHYSICAL HEALTH

_____ Active Medical Problems _____ Past Hospitalizations _____ Current Medications
_____ Major Medical Illness _____ Other Medical Problems (describe) ______________
If "Yes," describe: ______________________________
Do you currently have any medical problems that are not being treated by a doctor, but should be?
_____ No _____ Yes (describe) ______________________________

List any 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
Describe changes marked above: ______________________________
____
____

CHEMICAL USE HISTORY

Have you ever used any illegal drugs? _____ No _____ Yes (describe) ______________
____

Do you drink alcohol? _____ No _____ Yes (describe frequency and amount) ______________
____

Have any of your family members or significant relationships had a problem with drugs or alcohol?
_____ No _____ Yes (describe who and circumstances) ______________
____

Describe how drugs or alcohol have affected your life: ______________
____

COUNSELING / PRIOR TREATMENT HISTORY

Have you ever participated in any counseling/therapy services? _____ No _____ Yes (describe when/where)
____
____

Are you currently seeing another therapist? _____ No _____ Yes If so, who? ______________
Have any of your family members or significant relationships been involved in counseling or treatment?
_____ No _____ Yes (describe) ______________________________
____

Have you ever been hospitalized for drugs/alcohol/psychiatric care? _____ No _____ Yes (when/where)
____
____

Have you ever been involved in any self-help groups (AA, NA, Al-Anon, etc.)? _____ No _____ Yes
Which ones? ______________________________
Have you ever attempted suicide or had suicidal thoughts? _____ No _____ Yes (describe)
____
____

Are you feeling suicidal now? _____ No _____ Yes

CLIENT OPINION ABOUT STRENGTHS AND NEEDS

What do you see as your/your family strengths?

____
____
____
____
____
____

Is there any other information about you that you think is relevant for your treatment planning?

____
____
____
____
____
____

Please list at least one goal you would like to reach during the course of your treatment.

____
____
____
____
____
____

______________________________________ ____________
SIGNATURE OF PERSON COMPLETING THIS FORM DATE

____
RELATIONSHIP TO THE CLIENT