Adult Personal and Health History Form

MIGHTY OAK
CHRISTIAN COUNSELING

A. Identification Data

Client's Name _____ SSN _____-_____-_____
Date _____ Best number to reach you _____ ☐Home ☐Cell ☐Work ☐Other
Address _____City/State_____
Zip_____ Nationality or Ethnic Background _____
Gender _____ Birthdate _____/_____/_____ Age_____ Email _____
Martial Status: ☐ Single ☐ Exclusively Dating ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Education (circle last year completed)
Grade School 1 2 3 4 5 6 7 8 High School 9 10 11 12 College 1 2 3 4 5 6+
Other Training (list type and years) _____
_____
Current Occupation_____ Current Employer_____
Previous Employment_____ Reason for leaving_____
_____
Describe any military experience _____
_____
Church/Synagogue_____ Pastor/Rabbi_____
Usual Church Attendance _____times per ☐ Week ☐ Month ☐ Year ☐ Am not attending currently
How important is your faith/spirituality to daily life? _____

B. Health History

Rate your physical health (check) ☐ Very good ☐ Good ☐ Average ☐ Declining
Your approximate weight (lbs.) _____ recent weight changes Lost ____ Gained ____ Height _____
List all significant present or past illnesses, injuries, hospitalizations, or disabilities _____
_____
_____
Current Primary Care Physician _____Date of last medical exam _____
Other Physicians treating you presently or in the last five years _____
Date of last visit _____ Recent Medical Reports? _____
Describe briefly your history of drug and alcohol intake _____
_____
Do you currently drink alcoholic beverages? ☐No ☐Yes If so, how many drinks per week? _____
Do you currently use illegal substances? ☐No ☐Yes If so, what and how much _____
Do you currently drink caffeinated beverages? ☐No ☐Yes If so, how many per day? _____
Do you currently use tobacco in any form? ☐No ☐Yes If so, what and how much? _____
For women only. Is there anything about your menstruation cycle or birthing/pregnancy history that would be important for us to know? ☐No ☐Yes If yes, please explain _____
_____
_____

C. Health habits

What kind of physical exercise do you get? _____
_____ How often? _____

Do you try to restrict your eating in any way? ☐No ☐Yes If yes, how and why? _____
_____

Do you have any problems getting enough sleep? ☐No ☐Yes If yes, what problems? _____
_____

Are you taking any medications prescribed by a physician? ☐No ☐Yes If yes, please list below

Medication Date began Daily Dose Condition treated Prescribing physician

_____
_____
_____
_____

"over the counter" or herbal supplements medications _____
_____

D. Mental Health History

Are there any other medical or physical problems you are concerned about? _____
_____
_____

Have you ever had a severe emotional upset? ☐No ☐Yes

Have you ever had any psychotherapy before or counseling? ☐No ☐Yes

If yes, list counselor/therapist, dates of service and reason for seeking treatment _____
_____
_____

Have you ever been hospitalized for mental health reasons? ☐No ☐Yes If yes, please give details including name of hospital, length of stay, reason for stay _____
_____

Have you ever attempted suicide? ☐No ☐Yes If so, when and in what matter? _____
_____
_____

E. Legal History

Have you ever been arrested? ☐No ☐Yes If yes, describe the charges and circumstances _____
_____

Have you ever been physically or emotionally abusive or been treated in a physical or emotional abusive manner in an intimate (marital/dating) relationship? If yes, please describe
_____
_____

Have you ever been physically or emotionally abusive to a child, parent or pet? If yes, please describe __
_____
_____

Have you ever sought a protection order against anyone or had a protection order taken out against you? ☐No ☐Yes If yes, when/who _____

_____

Have you ever been afraid that your current partner/spouse would physically harm you? ☐No ☐Yes

F. Marriage Information (if never married, check ☐and omit this section)

Name of spouse _____ Length of marriage: _____ years _____ months

Age when married: My age _____ My partners age _____

Have you ever been separated? ☐No ☐Yes If yes, when and for how long? _____

Have either of you filed for divorce? ☐No ☐Yes If yes, when? _____

How long did you know each other before marriage? ___ years ___ months Length of engagement ____

Describe your spouse and your relationship with him/her _____

_____

_____

Give brief information about any previous marriages. If present is only marriage check ☐ and omit this section. _____

_____

G. Information about children

Name	Age	Grade last completed	Relevant Comments
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Other family members or Non-family members living in the home

Name	Age	Relevant Comments
_____	____	_____
_____	____	_____

H. Parental/Family History

If raised by someone other than your parents, please explain _____

_____ Are you adopted ☐No ☐Yes

Are your parents still living (yes/no) Mother? ____ Father? ____

Occupation of Father? _____ Mother? _____

Describe your religious/spiritual upbringing: _____

_____

If alive, are your parents still living together? ☐No ☐Yes If no, explain_____

_____

Describe their marriage _____

_____

Did either parent/caretaker drink excessively or use drugs? ☐No ☐Yes if yes, explain _____

_____

Who did you feel closest to growing up? _____
_____

Rate your childhood ☐Very happy ☐Happy ☐Average ☐Unhappy ☐Very unhappy

List your brothers and sisters and their ages:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Describe what it was like growing up in your family: _____
_____
_____
_____

List any aunts, uncles, grandparents, parents, or siblings that have had alcohol/drug problems or mental health problems. _____
_____
_____

List any suicide attempts by family members: _____
_____
_____

Has anything happened recently that has caused problems in your family of origin? _____
_____
_____

Have there been any recent losses?

_____
_____

I. Strengths and Supports

Who do you consider to be part of your current support system? _____
_____

What do you think your personal strengths/positive qualities are? What are you good at? _____
_____
_____
_____

J. Current Functioning

Describe the main reason you are seeking counseling. _____
_____
_____
_____

How long have you been experiencing this? _____

How has this issue been affecting you daily? _____
_____
_____
_____

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Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" packet. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I understand the payment/fee for service policies of Mighty Oak Christian Counseling.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be allowed to reschedule with a $10.00 fee. Repeated no-show and no-call ahead missed appointments will lead to closure of services.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or person acting for client) Date

_____ _____
Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and response give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date

☐Copy accepted by client ☐Copy declined by client

Client Information

Client Information

Client Name: _____ DOB:_____ Sex:_____
SSN: _____ Phone #: _____☐ home ☐cell ☐work
Address:_____
Email: _____

Contact Information

If our office needs to contact the client what is the best # to call? _____
Is it ok for us to leave a message on voicemail/answering machine? _____
Is it ok to leave a message with someone besides yourself at your number? _____
List the individuals a message may be left with: _____
_____
_____

Payment Options

___ I plan to pay at time of service or through prearranged billing contract.

___ I would like the service submitted to my insurance and understand that I may still be responsible for all or a portion of the fee.

Insurance

Insured Party: _____ Relationship to Client: _____
Address: _____
Insurance Company: _____ Phone #: _____
Policy #: _____ Group #:_____
Insured Party SSN: _____ Insured Party DOB: _____

Secondary Insurance

Dual Coverage? _____ 2nd Insurance Company: _____
Insured Party: _____ Relationship to Client: _____
Phone #: _____ Address: _____
Policy #: _____ Group #: _____
Insured Party SSN: _____ Insured Party DOB: _____

I verify that the above information is factual and true to the best of my knowledge. If noted, I authorize the office to bill/submit services to insurance. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Client Date