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PERSONAL HISTORY- ADULT

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of Birth: _____ Age: _____

Form completed by (if someone other than client): _____

Primary reason(s) for seeking services:

__ Anger management ____ Anxiety ____ Coping ____ Depression

__ Eating disorder ____ Fear/phobias ____ Family Conflict ____ Noncompliance

__ Sleeping problems ____ Obsessive/Compulsive behaviors ____ Alcohol/drugs

__ Hyperactivity ____ Work Problems ____ Social Problems ____ Trauma

__ Other concerns (specify): _____

_____

_____

_____

_____

Family Information

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

Significant others (e.g., 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
Length of time: _____

___ Unmarried, living together
Length of time: _____

__ Legally married
Length of time: _____

___ Separated
Length of time: _____

___ Divorced
Length of time: _____

__ Widowed
Length of time _____

___ Annulment
Length of time: _____

Total number of marriages: __

Assessment of current relationship (if applicable): ____ Good ____ Fair ____Poor

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.): _____

Family Health & Mental Health History

Have any of the following diseases occurred among your blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

__ Depression	___ Anxiety	___ Autism/Other PDD
__ ADHD	___ Schizophrenia	___ Bipolar Disorder
__ Migraines	___ Muscular Dystrophy	___ Seizures
__ Suicide	___ Mental Retardation	___ Other (specify): _____
__ Cancer	___ Stomach Problems	___ Other (specify): _____

Comments re: Family Health/Mental Health_____

_____

Development

Are there special, unusual, or traumatic circumstances that affected your development? __ Yes __No
If Yes, please describe: _____
Has there been a history of child abuse? __ Yes __ No
If Yes, which type(s)? __ Sexual __ Physical __ Verbal
If Yes, the abuse was as a: __ Victim __ Perpetrator
Other childhood issues:

_____

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 recent or past history of being a sexual perpetrator? __ Yes __ No
If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? __ Yes __ No
If Yes, describe: _____

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: _____
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 an indicate the court and hearing/trial dates and charges: _____
_____
Are you presently on probation or parole? __ Yes __ No
If Yes, please describe: _____

Past History

Criminal involvement: __ Yes __ No DWI, DUI, etc.: __ Yes __ No
If you responded Yes to any of the above, please explain: _____
_____

Education

Fill in all that apply: Years of education: ____ Currently enrolled in school? __ Yes __ No
__ High school grad/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 absent?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: __ FT __ PT __ Temp __ Laid-off __ Disabled __ Retired
__Social Security __ Student __ Other (describe): _____

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?

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

Health History

List any current health concerns: _____

_____

_____

List any recent health or physical changes: _____

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: _____

_____

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/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

	Method of use and amount	Frequency of use and amount	Age of first use	Age of last use	Used in last 48 hours (circle one)		Used in last 30 days (circle one)	
Alcohol	_____	_____	_____	_____	Yes	No	Yes	No
Barbiturates	_____	_____	_____	_____	Yes	No	Yes	No
Valium/Librium	_____	_____	_____	_____	Yes	No	Yes	No
Cocaine/Crack	_____	_____	_____	_____	Yes	No	Yes	No
Heroin/Opiates	_____	_____	_____	_____	Yes	No	Yes	No
Marijuana	_____	_____	_____	_____	Yes	No	Yes	No
PCP/LSD/Mescaline	_____	_____	_____	_____	Yes	No	Yes	No
Inhalants	_____	_____	_____	_____	Yes	No	Yes	No
Caffeine	_____	_____	_____	_____	Yes	No	Yes	No
Nicotine	_____	_____	_____	_____	Yes	No	Yes	No
Over the counter	_____	_____	_____	_____	Yes	No	Yes	No

Prescription drugs	_____	_____	_____	_____	Yes	No	Yes	No
Other drugs	_____	_____	_____	_____	Yes	No	Yes	No

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use 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	Your reaction to overall experience
Counseling	____	____	_____	_____	_____
Psychiatric Treatment	____	____	_____	_____	_____
Drug/alcohol treatment	____	____	_____	_____	_____
Hospitalizations	____	____	_____	_____	_____
Self-help groups (e.g., AA, NA, Al-Anon, etc.)	____	____	_____	_____	_____

Have you ever been suicidal? If so, when? _____

_____

Please check behaviors and symptoms that occur more often than you would like:

__ 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	___ Sleep 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 affect your life: _____

_____

_____

_____

_____

_____

_____

_____

Any additional information that would assist us in understanding your concerns or problems: _

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____

Do you feel suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

For Therapist's Use Only

Reviewed by:
Therapist's signature/credentials: Date: