

Personal History Form

Client's name: _____

Gender: _____ F _____ M Date of birth: ____/____/____ Age: _____

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

Address: _____ City/State/Zip: _____

Phone (home) _____ (Work): _____ (Cell): _____

If client is a minor, parents' names: _____

If parents are not married, who has legal custody? ___ Mother ___ Father ___ Other: _____

If parents are not married, explain physical custody arrangements: _____

Primary reason(s) for seeking services:

_____ Anger Management _____ Anxiety _____ Coping
_____ Depression _____ Eating Disorder _____ Fear/Phobias
_____ Mental confusion _____ Sexual Concerns _____ Sleeping problems
_____ Addictive behaviors _____ Alcohol/drugs
_____ Other: _____

Marital Status (more than one answer may apply)

___ Single ___ Married ___ Separated ___ Divorced ___ Widowed Total number of marriages: _____

Assessment of current relationship (if applicable): _____ Good _____ Fair _____ Poor _____ Abusive

Number of biological children and ages: _____

Number of step children and ages: _____

People living in your home other than your immediate family: _____

Client Parental Information

Are your parents still living? _____

_____ Parents are/were legally married

_____ Parents are/were 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.): _____

Development History

Are there special, unusual, or traumatic circumstances that affected your development? _____ Yes _____ No

If yes, please describe: _____

Has there been 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: Neglect Inadequate nutrition Other: _____

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 Friendly Leader Outgoing Shy/withdrawn Submissive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 sexual abuse? Yes No

If Yes, describe: _____

Cultural/Ethnic (optional)

To which cultural or ethnic group, of any, do you belong? _____

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 or members of your imitate family 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 Legal History

Traffic Violations: Yes No DWI, DUI, etc: Yes No

Criminal Involvement: Yes No Civil involvement: Yes No

Education

Currently enrolled in school? No Yes; Name of school: _____ Grade: _____

Education Level:

High school grad/GED

College

Vocational

Graduate School

Some College

Military Training

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Were you or have you been expelled or suspended from a school that you attended? _____

If yes, explain: _____

Employment/School

Employer: _____ Title: _____

How often do you miss work/school? _____

Current Employment Status:

FT

Disabled

PT

Retired

Temp

Student

Laid-off

Other (describe) _____

How many jobs have you held in the last 5 years? _____

Military

Military experience? Yes No

Combat experience? Yes No

Where: _____

Branch: _____

Discharge date: _____

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).

Have you had a reduced interest in any of these activities? _____

Medical/Physical Health

Current health issues: _____

List any recent health, physical changes or surgeries: _____

Current prescribed medications: _____

Current over-the-counter: _____

Are you allergic to any medications or latex? ____ 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

	Frequency of use	Age of first use	Age of last use	Used in last		Used in last	
				48 hours		30 days	
				Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____
Meth	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____

Counseling/Prior Treatment History

Previous therapy history: _____

Suicidal thoughts or attempts: _____

Homicidal thoughts or attempts: _____

Has anyone in your family been treated for a serious mental disorder or drug addiction? _____

(Family members) Suicidal/homicidal thoughts or attempts: _____

Please check behaviors and symptoms that are currently problematic:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? Yes No
If Yes, explain: _____

If Yes, do you have a plan? _____

Additional Information: _____

