



ADULT PERSONAL HISTORY FORM

Case # _____

Client's Full Name _____ Date _____

Gender F M Date of Birth _____ Age _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

D.L. # _____ S.S. # _____

Occupation _____ Employer _____

Employment Address _____ City _____ State _____ Zip _____

Health Problems _____ Current Medications _____

Family Physician _____ Phone _____

Prior Experience with Therapy? Y N When? _____ Where? _____

Therapist's Name _____ How was the experience? _____

REFERRAL INFORMATION

Reason for referral _____

Referred by _____ Referral Phone Number _____

May we thank the referral source? Y N

When and Why do you think the problem began? _____

Do others notice this problem? Y N Who? _____

Estimate the severity of the problem: Mild Moderate Severe Extremely Severe

CULTURAL/ETHNIC

From which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? N Y (Please describe) _____

Other cultural/ethnic information _____

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?

FAMILY INFORMATION

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

Marital Status: Single Divorce in process Unmarried, living together Separated
 Married Divorced Widowed Annulment

For how long? _____

Total # of Marriages _____ Assessment of Current Relationship: Good Fair Poor

Parental Information

Parents legally married Parents divorced
 Parents ever separated Mother remarried Father remarried

DEVELOPMENT

Are there special, unusual, or traumatic circumstances that affected your development? N Y

Did you experience abuse? Sexual Physical Verbal Abuse was as: Victim Perpetrator

Other childhood issues: Neglect Inadequate nutrition Other (*specify*) _____

Comments re: childhood development: _____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason for leaving	How often missed work

Currently: FT PT Temp Disabled Retired Social Security Student

Other (*describe*) _____

SOCIAL RELATIONSHIPS

How do you generally get along with people? (check all that apply)

Affectionate Aggressive Avoidant Fight/argue often Follower
 Friendly Leader Outgoing Shy/withdrawn Submissive
 Other (specify) _____

Are you currently sexually active? N Y

Sexual Orientation: _____ Sexual Dysfunctions: _____

Any current or history of being a sexual perpetrator? N Y (describe) _____

EDUCATIONAL

Fill in all that apply Years of education _____ Currently enrolled in school? Y N

High school grad/GED Vocational: # of yrs _____ Graduated? Y N Major _____
 College: # of yrs _____ Graduated? Y N Major _____
 Graduate: # of yrs _____ Graduated? Y N Major _____

Other training: _____

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

LEGAL

Are you involved in any active cases (traffic, civil, criminal)? N Y

If yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? N Y Name & # of Probation Officer _____

If yes, please describe the circumstances: _____

Traffic Violations Y N DWI, DUI, etc. Y N

Criminal Involvement Y N Civil Involvement Y N

If you responded yes to any of the above, please complete the following information:

Charges	Date	Where (city)	Results

Military Experience? Y N Combat Experience? Y N Where? _____

Branch _____ Discharge Date _____ Type of Discharge _____

Date Drafted _____ Date Enlisted _____ Rank at discharge _____

MEDICAL/PHYSICAL HEALTH

Check all that apply and describe below:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Colds/coughs | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Dental problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Miscarraiges | <input type="checkbox"/> Toothaches |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other (<i>describe</i>) |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever | |

List any current health concerns: _____

Nutrition

Meal	Times / week	Typical Food Eaten	Typical Amount Eaten	Comments
Breakfast	___ /week		__Low __Med __High	
Lunch	___ /week		__Low __Med __High	
Dinner	___ /week		__Low __Med __High	

Current Medications: _____

Describe your Sleep Schedule: _____

	Date	Reason	Results
Last Physical Exam			
Last Dental Exam			
Last Surgery			

Family History of Medical Problems: _____

Please check if there have been any recent changes in the following:

- | | | | |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Sleep Patterns | <input type="checkbox"/> Eating Patterns | <input type="checkbox"/> Behavior | <input type="checkbox"/> Energy Level |
| <input type="checkbox"/> Physical Activity Level | <input type="checkbox"/> General Disposition | <input type="checkbox"/> Weight | <input type="checkbox"/> Tension/Nervousness |

Describe changes in the areas checked above: _____

SPIRITUAL

How important to you are spritual matters? ___Not ___Little ___Moderate ___Very

Were you raised within a spritual or religious group? ___N ___Y (*specify*) _____

Would you like your spritual/religious beliefs incorporated into the counseling? ___N ___Y (*specify*) _____

CHEMICAL USE HISTORY

Have you ever used any of the following:

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Valium/Librium	<input type="checkbox"/> Cocaine/Crack
<input type="checkbox"/> Heroin/Opiates	<input type="checkbox"/> Marijuana	<input type="checkbox"/> PCP/LSD/Mescaline	<input type="checkbox"/> Inhalants
<input type="checkbox"/> Caffeine	<input type="checkbox"/> Nicotine	<input type="checkbox"/> Prescription Drugs	<input type="checkbox"/> Other

For any of the checked items above, please describe use history (*when started, current usage, frequency*):

Describe when and where you typically use substances _____

Describe any changes in your substance use pattern _____

Does someone in your family have problems with drugs or alcohol? N Y (*specify*) _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? N Y

Do you have an AA sponsor? N Y (*specify name and number*) _____

SYMPTOMS/GOALS

Please check behaviors and symptoms that occur to you more frequently that you would like:

<input type="checkbox"/> Aggression	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Alcohol Dependence	<input type="checkbox"/> Drug Dependence	<input type="checkbox"/> Judgement Errors	<input type="checkbox"/> Speech Problems
<input type="checkbox"/> Anger	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Elevated Mood	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Thoughts Disorganized
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Mood Shifts	<input type="checkbox"/> Trembling
<input type="checkbox"/> Avoiding People	<input type="checkbox"/> Gambling	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Withdrawing
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Phobias/Fears	<input type="checkbox"/> Worrying
<input type="checkbox"/> Cyber Addiction	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Recurring Thoughts	<input type="checkbox"/> Other (<i>specify</i>)
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sexual Addiction	_____
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Sexual Difficulties	_____
<input type="checkbox"/> Distractability	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Sick Often	_____

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

Any additional information that would assist us in understanding your concerns or problems? _____

What are your top 3 desired outcomes/goals for therapy? _____

Have you ever attempted suicide? N Y (*explain and dates*) _____

INSURANCE

Please provide us with your insurance information:

Insurance Provider _____ Plan Number _____

Provider Address & Telephone _____