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Adult Personal History Form

CLIENT NAME: _____ DOB: _____ DATE: _____

Please take your time and complete entire form. The information will help me understand you better. Use the back of the sheet if necessary.

FAMILY BACKGROUND

Full Name	**Year of Birth**	**If Deceased, year/cause**
Mother		
Father		
Other Parental Figure		
Siblings		
Stepsiblings		
Spouse/Partner		
Former spouse/partner		
Children		
Stepchildren (Identify their parent)		

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Marital Status :

Unmarried _____
Live together _____ How many years? _____
Married _____ How many years? _____
Separated _____ How many years? _____
Divorced _____ How many years? _____
Widowed _____ How many years? _____

Number of times married: _____

Who lives in your home now? _____

You were raised by: _____

Family members you are close to now: _____

Ethnic Background: _____

Any ethnic problems/concerns? _____

PERSONAL HISTORY

Religious/spiritual background: _____

Current religious/spiritual activity: _____

Do you have any spiritual concerns now? _____

Education: Last grade completed: _____ Degree: _____ In school now? _____

Special training or skills: _____

Are you hoping or planning to go to school?_____

Do you have a learning difference? _____

What do you do for a living? _____

Employer: _____ Years on job: _____ Pay rate: _____

If no job, when did you last work? _____ Are you looking for work now? _____

Any job problems now? _____

Ever been fired? _____ How many times: _____ Why? _____

Do you have any financial problems? _____

What financial aid do you receive? _____ Amount: _____

What aid does rest of family get?_____ Amount: _____

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COUNSELING INFORMATION

What prompted you to want to start counseling? _____

_____

_____

How would you like me to help you? _____

_____

_____

Circle any of the following that apply to you now or within the past month:

Blackouts/memory loss	Increased drug usage	Thoughts of harming others
Can't concentrate	Job stress	Thoughts of harming self
Confusion	Loneliness	Unusual thoughts
Crying spells	Loss of appetite	Withdrawal symptoms
Decreased activity	Mood swings	Loss of control in:
Depression	Nervous/Anxious	alcohol/drug use
Emptiness	Nightmares	endangering others
Fear of dying	Not seeing friends	endangering self
Feel controlled	Panic attacks	gambling
Feel talked about	Racing thoughts	hitting people
Financial worries	Relationship breakup	overeating/bingeing
Guilt/shame	School problems	purging
Hearing voices	Seeing things others don't	spending
Hoarding	Sexual problems	yelling/breaking things
Hopelessness	Sleep disturbance	Other:
Increased alcohol use	Suicide attempts/injuries	Other:

Please explain circled items: _____

_____

_____

_____

Have you ever self-injured or attempted to commit suicide or otherwise seriously harm yourself? _____

When? _____ How? _____

Has anyone in your family attempted or committed suicide? _____ Who?_____When? _____

Please explain: _____

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Have you ever attempted to kill or seriously harm someone else? _____ Who? _____

Explain: _____

Have you ever hit, slapped or choked any of your loved ones? _____

During arguments/fights do you threaten, throw or break things, punch the walls or slam doors, yell or scream at your partner or children?_____

Describe: _____

Is your partner afraid of you sometimes? _____ Are your children? _____

Do you feel guilty about your behavior afterward? _____

Have you ever been the victim of physical, sexual or verbal abuse?_____

Describe: _____

Describe any sexual concerns that you might have: _____

_____

PREVIOUS TREATMENT

Have you been hospitalized for depression, hearing voices or other mental or emotional problems?_____

How many times? _____ Any involuntary? _____ Year of first admission:_____ Where: _____

Reason: _____

Year of last admission: _____ Where: _____

Reason: _____

Have you received therapy previously? _____

Where/when: _____

Reason: _____

Have you ever been involved in any support groups (Emotions Anonymous, Recovery, Weight-Watcher, Incest Survivors, ACOA, Alanon, etc.)? _____When? _____Type of Group: _____

Reason: _____ Was it helpful? _____

Has anyone in your FAMILY ever been hospitalized for depression or any other mental or emotional problems?

Please explain who, when and reason: _____

_____

_____

_____

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LEGAL HISTORY

Have you ever been arrested? _____ When? _____ Where? _____

Please describe what happened: _____

_____

Are you currently on probation? _____ Parole? _____ Ending Date: _____

Are you involved in any lawsuits?_____

Any upcoming Court dates?_____

MILITARY SERVICE

Branch: _____ Service dates: _____

Where: _____

Assignment: _____

Honorable discharge? _____ If not, why? _____

Describe any combat experience:_____

Are you troubled now by your experience in the military? _____

INTERESTS AND ACTIVITIES (Circle all that apply):

Be alone	Gardening	Sex
Be with family	Get high	Shopping
Be with friends	Go to museums	Singing
Build/decorate	Hiking	Television
Camping	Movies/videos/DVDs	Travel/sight-see
Care for elderly	Music listening	Video games
Child-care	Photography	Volunteer work
Cooking/eating	Play instrument	Watch sports
Dancing	Play sports	Writing
Drawing	Prayer/Religion	Other:
Exercise	Reading	Other:
Fix/repair things	School	Other:
Gambling	Sew/knit/crochet	Other:

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Have you recently lost interest in activities you normally enjoy? _____

Do you feel you spend enough time on your interests or non-work activity? _____

PHYSICAL HEALTH

Date of last physical: _____ Results: _____

Do you eat a regular balanced diet? _____ Do you skip meals? _____

Any poor eating/junk-food habits? _____

Do you exercise regularly? _____ How often? _____

For women: Number of pregnancies? _____ Live births: _____ Adoptions: _____

Normal menstrual cycle? _____ Are you pregnant?_____

Premenstrual syndrome? _____ Menopause? _____ Hormone therapy? _____

Please circle any health concerns below

	Date of Onset	**Description**	**Impact on Daily Life (Low/Medium/High)**
Accidents			
AIDS			
Allergies			
Asthma			
Birth defect			
Cancer			
Chronic fatigue syndrome			
Chronic pain			
Dental problems			
Diabetes			
Gastrointestinal problems			
Head injuries			
Hearing problems			
Heart disease			
Hepatitis			
High Blood Pressure			
Hypoglycemia			
Impotence			
Low Blood Pressure			
Major surgeries			
Physical Abuse			
Positive HIV			
Seizures			
Severe headaches/migraines			

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STD			
Thyroid Problems			
Vision problems			
Weight gain			
Weight loss			
Other			

MEDICATION HISTORY (current and within past two years)

Medication	Dosage	Frequency	Prescriber	Date Prescribed	Still Used?	Does it Help?

ALCOHOL AND DRUG HISTORY

How many days a month do you: drink _____ use non-prescribed drugs?_____

Do you ever drink or use drugs more than you planned to? _____

Do you ever experience memory lapses when drinking or using drugs? _____

Have you ever overdosed _____ or experienced withdrawal symptoms? _____

Explain:_____

What's the longest period you remained totally alcohol/drug-free? _____

What helps you to stay sober? _____

Did you ever receive hospital or residential treatment for an alcohol or drug-related problem? _____

How many times? _____

Where/When: _____

Have you ever received any outpatient alcohol/drug treatment? _____

Where/When: _____

Have you been involved in alcohol/drug support groups (AA, NA, etc.)? _____

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Where/When: _____ Was it helpful?_____

Has any family member/loved one ever had a drinking or drug problem? _____

Who? _____ Please describe:_____

_____

_____

Has drinking or drugs ever caused problems in any of the following areas:

family _____ employment _____ legal _____ emotional _____
social _____ financial _____ behavior _____ physical _____

Does a relative, loved one, friend, court or employer think so? _____

Please explain_____

	Age of First Use	Age used regularly	Average Number of Days per Week Used	How Much Used Daily	How Much Used in Past 30 Days	Date You Last Used
Alcohol Type:						
Amphetamines Name:						
Anti-anxiety medication: Name:						
Cigarettes						
Cocaine						
Coffee, Cola Caffeine pills						
Hallucinogenics Name:						
Heroin						
Marijuana/Hash						
Meth-amphetamine						
Methadone						
Muscle Relaxers Name:						
Pain Medication Name:						
Sleeping pills Name:						

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Steroids Name:						
Other:						
Other:						

Client signature: _____

Name of person who helped you complete this form: _____

Relationship to you: _____