Personal History—Adult

Client's name: _____ Date: _____

Gender: ____F ____ M Date of birth: _____ Age: _____

Social Security Number:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ Ext: _____

Phone (cell):_____

Current Employment:_____

If you need any more space for any of the following questions please use the back of the sheet.

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 ____ Hyperactivity
____ Other mental health concerns (specify): _____

FAMILY HISTORY

PLEASE WRITE DOWN THE PEOPLE WHO LIVE IN YOUR HOME AND THEIR RELATIONSHIP TO YOU.

Name	Relationship	Age	Gender	Quality of relationship with the client
_____	_____	___ F ___ M	___ poor ___ average ___ good	
_____	_____	___ F ___ M	___ poor ___ average ___ good	
_____	_____	___ F ___ M	___ poor ___ average ___ good	
_____	_____	___ F ___ M	___ poor ___ average ___ good	

Other Children that may not live with you in the home

Name	Relationship	Age	Gender	Quality of relationship with the client
_____	_____	___ F ___ M	___ poor ___ average ___ good	
_____	_____	___ F ___ M	___ poor ___ average ___ good	
_____	_____	___ F ___ M	___ poor ___ average ___ good	

Comments: _____

SOCIAL HISTORY

Do you have close relationships with people for whom you can rely on for support? YES NO

Do you have difficulty starting or maintaining relationships with others? YES NO

EDUCATION

Highest Level of Education:_____

Did you have any problems in school with behavior or grades? If yes, please explain:_____

_____

Grades in school:_____

EMPLOYMENT HISTORY

Current Employer and position:_____

Length of employment:_____

Do you have difficulties maintaining a job or any job related duties? If yes please explain:_____

_____

MEDICAL/PHYSICAL HEALTH

___Abortion
___ Asthma
___ Blackouts
___ Bronchitis
___ Cerebral palsy
___ Chicken pox
___ Congenital problems
___ Croup
___ Diabetes
___ Diphtheria
___ Dizziness
___ Earaches
___ Ear infections
___ Eczema
___ Encephalitis
___ Fevers
___ Hay fever
___ Heart trouble
___ Hepatitis
___ Hives
___ Influenza
___ Lead poisoning
___ Measles
___ Meningitis
___ Miscarriage
___ Multiple sclerosis
___ Mumps
___ Muscular dystrophy
___ Nosebleeds
___ Other skin rashes
___ Paralysis
___ Pleurisy
___ Pneumonia
___ Polio
___ Pregnancy
___ Rheumatic fever
___ Scarlet fever
___ Seizures
___ Severe colds
___ Severe head injury
___ Sexually transmitted disease
___ Thyroid disorders
___ Vision problems
___ Wearing glasses
___ Whooping cough
___ Other
_____

List any current health concerns: _____

_____

List any recent health or physical changes: _____

_____

NUTRITION

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High

Dinner ___ / week _____ ___ No ___ Low ___ Med ___ High

Snacks ___ / week _____ ___ No ___ Low ___ Med ___ High

Comments: _____

SLEEP

Total # Hrs slept per night:_____ Total # Awakening per night:_____

Time Go to Bed:_____ Time Fall Asleep:_____ Time Wake Up:_____

Do You Feel Rested When you Wake Up? Y N

Do you experience any of the following (check all that apply):

___ Snore ___ Move while you sleep ___ Sleepwalk
___ Night Terrors ___ Nightmares ___Talk in your sleep
___ Stop Breathing in sleep ___ Trouble falling asleep ___ Trouble staying asleep
___ Tired during the day ___Fall asleep in daytime ___Watch tv or read in bed
___Sleep with lights on ___Share a room/bed
___Need someone with you to fall asleep ___Other:_____

MOST RECENT PHYSICAL EXAMINATION

Type of examination	Date of most recent visit	Results
Physical examination	_____	_____

Surgeries? _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CHEMICAL USE HISTORY

How often do you consume alcohol and illegal substances?_____

_____

Do you use or have a problem with alcohol or drugs? ___ Yes ___ No

Has anyone close to you thought you had a problem with alcohol or drugs? ___ Yes ___ No

Have you ever tried to reduce the amount of time you use alcohol or drugs? ___ Yes ___ No

Have you ever been in trouble with family, work, or the law due to alcohol or drugs? ___ Yes ___ No

Legal History

Have you experienced any legal difficulties in the past or are currently involved in legal issues at this time (e.g. DUI, custody hearings, disability evaluations, prison time). If yes please explain._____

_____

Are you currently or have you been on probation at any time? Please explain details._____

_____

Are you planning to contact a lawyer anytime in the near future? If yes please explain._____

_____

COUNSELING/PRIOR TREATMENT HISTORY

Please list any services received for mental health concerns (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

BEHAVIORAL/EMOTIONAL

Please check any of the following that apply to you:

___ Affectionate
___ Aggressive
___ Alcohol problems
___ Angry
___ Anxiety
___ Attachment to dolls
___ Avoids adults
___ Bedwetting
___ Blinking, jerking
___ Bizarre behavior
___ Bullies, threatens
___ Careless, reckless
___ Chest pains
___ Clumsy
___ Confident
___ Cooperative
___ Cyber addiction
___ Defiant
___ Depression
___ Destructive
___ Difficulty speaking
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Enthusiastic
___ Excessive masturbation
___ Expects failure
___ Fatigue
___ Fearful
___ Frequent injuries
___ Frustrated easily
___ Gambling
___ Generous
___ Hallucinations
___ Head banging
___ Heart problems
___ Hopelessness
___ Hurts animals
___ Imaginary friends
___ Impulsive
___ Irritable
___ Lazy
___ Learning problems
___ Lies frequently
___ Listens to reason
___ Loner
___ Low self-esteem
___ Messy
___ Moody
___ Nightmares
___ Obedient
___ Often sick
___ Oppositional
___ Overactive
___ Overweight
___ Panic attacks
___ Phobias
___ Poor appetite
___ Psychiatric problems
___ Quarrels
___ Sad
___ Selfish
___ Separation anxiety
___ Sets fires
___ Sexual addiction
___ Sexual acting out
___ Shares
___ Sick often
___ Short attention span
___ Shy, timid
___ Sleeping problems
___ Slow moving
___ Soiling
___ Speech problems
___ Steals
___ Stomachaches
___ Suicidal threats
___ Suicidal attempts
___ Talks back
___ Teeth grinding
___ Thumb sucking
___ Tics or twitching
___ Unsafe behaviors
___ Unusual thinking
___ Weight loss
___ Withdrawn
___ Worries excessively
___ Other:
_____
_____

Please describe any of the above (or other) concerns:_____

_____

Have there been any significant changes or events in your life? (family, moving, fire, etc.)

___ Yes ___ No If Yes, describe: ___

Any additional information that you believe would assist us in understanding you and your presenting complaints?

What are your goals for therapy?