PERSONAL HISTORY INFORMATION (ADULT)

Name:_____SSN#_____

Street:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Work #_____

Cell:_____Email:_____

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Age:_____ Date of Birth:_____

Occupation:_____ Place of Employment:_____

How were you referred ?_____

In case of emergency, contact name_____

Relationship to client_____Phone(____)_____

HIGHEST LEVEL OF EDUCATION: PhD MA BA High School Jr. High Elem

Issues for which you are seeking assistance:

Are there precipitating events contributing to these issues? What is the history of your issues?

What is your desired outcome from therapy?

What are your perceived strengths and abilities?

RELIGIOUS INFORMATION: Religion_____

Were you affiliated with a church as a child/adolescent? Yes_____ No_____

Are you affiliated with a church? Yes_____ No_____

Denomination_____

CULTURAL/ETHNIC INFORMATION

What cultural or ethnic group do you come from?

_____

Do you closely identify with this group? Yes_____ No_____

What strengths have you acquired from this identity?

Please check ALL of the following that <u>presently</u> apply to you :

___ Always tired ___Poor appetite ___Trouble sleeping ___Loss of weight
___Lack of energy ___Fast heartbeat ___Frequent sweaty ___Weight gain
___Full of energy ___Crying spells ___Unable to have fun ___Feeling easily hurt
___Dizziness ___Shaking hands ___Stomach trouble ___Feeling tense
___Cold hands/feet ___Diarrhea ___Constipation ___Muscle twitching
___Nausea/Vomit ___Headaches ___Fainting spells ___Poor physical health
___Depressed ___Feeling lonely ___Lacking confidence ___Feeling grouchy
___Anger ___Suicidal thoughts ___Nightmares ___Not enjoying things
___Feeling inferior ___Feeling panicky ___Always worried ___Impatient
___Shy with people ___Quick tempered ___Can't make friends ___No one understands me
___Fearful ___Unable to relax ___Can't make decisions ___Loss of sexual interest
___Easily excited ___Very restless ___Unable to Pray ___Sexual Problems
___Feeling guilty ___Anxious Inside ___Homosexuality Issues

___Financial Problems ___Marital Problems ___Difficulties at Work
___Excess Drinking
___Can't Hold a Job ___Problems with Kids ___Problems with Parents
___Excess Medic. Use
___Fighting/Quarreling ___Difficulties in School ___Difficulties with the Law
___Untruthfulness
___Loss of Meaning ___Unresolved Grief ___Confused about Religion
___Unable to Forgive

_____

SOCIAL HISTORY

Family Information: **Name** **Age**

Mother_____

Father_____

Spouse_____

Children_____

Describe your family of origin (e.g., emotional dynamics, relationships, and patterns of dysfunction):

_____

_____

What were your family's strengths and resources?

_____

_____

Describe how you relate to people (e.g., easily, shy, leader, follower):

_____

With whom do you socialize?

_____

Do you isolate yourself from others? Yes_____ No_____

Do you currently use self-injury to cope with problems? Yes _____ No_____

Have you self-injured in the past? Yes_____ No_____

Are you or have you been suicidal? Yes_____ No_____

SUBSTANCE ABUSE INFORMATION

Which of the following substances have you or do you presently use?

Type	Amount	Frequency
Alcohol		
Marijuana		
Cocaine		
Hallucinogens		
Amphetamines		
Pain Medication		
Sleeping Pills		
Tranquilizers		
Narcotics		
Other		

How often do you become intoxicated or high at the present time?

Never____ Once a month____ Once a week____ 2-3 times a week____ Daily____

Do you or a family member have a problem now or in the past with substance abuse? If yes, please explain:_____

MEDICAL HISTORY

Name of Physician:_____ Phone #_____

Please list current medications: dosage/frequency_____

Date of most recent physical exam:_____

Any abnormal results? Yes____ No____ If yes, please explain:_____

_____

How would you describe your general health? Good____ Fair____ Poor____

Are you experiencing any abnormal physical symptoms? Yes____ No____

If yes, please explain:_____

Are you currently receiving medical treatment? Yes____ No____

If yes, please explain_____

Do you, or any family members, have any chronic conditions (e.g., diabetes, anemia, cancer, asthma, heart disease, high blood pressure)? Yes____ No____

If yes, please explain_____

Do you have allergies? Yes____ No____ If yes, please explain_____

_____

Have you ever had any serious accidents or injuries? Yes____ No____ When? __/__/__ (date)

If yes, explain_____

Has any family member suffered from mental illness or severe depression? Yes__No__

If yes, please explain_____

Do you have any physical disabilities or limitations? Yes____ No____

If yes, please explain_____

Please list prior treatment for emotional and/or behavioral difficulties including outpatient and inpatient treatment and approximate dates:_____

_____

_____ _____

Client Signature and Date Therapist Signature and Date