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Personal History Form

All information included here will remain strictly confidential

Name____ Date________________________

What is the primary reason(s) you are seeking help at this time?

____

____

People commonly have some problems in the following categories. Please indicate how you are affected by each by circling the appropriate number beside the item. ***Please*** **check only ONE number for EVERY item.**

Not a Problem	A Slight Problem	A Moderate Problem	A Serious Problem	A Severe Problem
0	1	2	3	4

#	Item	Rating	#	Item	Rating
1	Feeling sad, depressed or unhappy	0 1 2 3 4	1	Euphoria (feeling high)	0 1 2 3 4
2	Feeling discouraged or hopeless	0 1 2 3 4	2	Sudden changes in mood for an apparent reason	0 1 2 3 4
3	Feeling bad about yourself - or that you are a	0 1 2 3 4	3	Decreased need for sleep (such as feeling	0 1 2 3 4
	failure or have let yourself or your family down			rested after only 3 hours of sleep	
4	Little interest or pleasure from things I usually enjoy	0 1 2 3 4	4	More talkative than usual	0 1 2 3 4
5	Feeling guilty, worthless, helpless	0 1 2 3 4	5	Racing thoughts	0 1 2 3 4
6	Crying spells	0 1 2 3 4	6	Acting Implusive (such as buying sprees, drinking	0 1 2 3 4
7	Restless, irritable or agitated	0 1 2 3 4		more, sexual activity)	
8	Feeling tired or having little energy	0 1 2 3 4	7	Excessive irritability or agitation	0 1 2 3 4
9	Trouble falling or staying asleep, or sleeping too much	0 1 2 3 4	8	Angry outbursts	0 1 2 3 4
10	Poor appetite or overeating	0 1 2 3 4	9	Property destruction	0 1 2 3 4
11	Trouble making decisions	0 1 2 3 4	1	Making careless mistakes at school, work or other activities	0 1 2 3 4
12	Difficulty with concentration	0 1 2 3 4	2	Difficulty sustaining attention during tasks	0 1 2 3 4
13	Less interest in sex	0 1 2 3 4	3	Difficulty following through or finishing things	0 1 2 3 4
14	Thoughts that you would be better off dead, or of hurting	0 1 2 3 4	4	Difficulty in organizing tasks or activities	0 1 2 3 4
	yourself in some way		5	Easily distracted	0 1 2 3 4
1	Anxious/nervous/worried	0 1 2 3 4	6	Losing things or forgetful	0 1 2 3 4
2	Stressed/overwhelmed	0 1 2 3 4	7	Hyperactivity (can't sit still)	0 1 2 3 4
3	Intense fear, panic/discomfort	0 1 2 3 4	8	Poor impulse control	0 1 2 3 4
4	Panic or fear with physical symptoms (such as pounding heart	0 1 2 3 4	1	Hearing things	0 1 2 3 4
	sweating, shaking, nausea, dizzy, fear of losing control)		2	Seeing things	0 1 2 3 4
5	Anxiety about being in certain situations (such as being in a	0 1 2 3 4	3	Experiencing confusion	0 1 2 3 4
	crowd, traveling, standing in line)		4	Memory lapses/forgetting	0 1 2 3 4
6	Anxiety or fear related to being in social situations having	0 1 2 3 4	5	Feeling of unreality or being outside of self	0 1 2 3 4
	to perform (such as public speaking, test taking)		6	"Missing time"	0 1 2 3 4
7	Fear, anxiety, or avoiding specific situations (such as flying,	0 1 2 3 4	7	Suspiciousness (questioning other people's motives)	0 1 2 3 4
	heights, animals)				
8	Worrying about health problems	0 1 2 3 4			
1	Having unwanted thoughts over and over again	0 1 2 3 4		I have been experiencing these problems for:	
2	Repeating specific acts over and over (such has hand washing	0 1 2 3 4		☐ < 1 Mo ☐ 1-6 Mos ☐ 7-12 Mos ☐ > 1 Year	
	checking etc. or mental acts (such as counting repeating words)				

Check any of the following that have caused concern or difficulties during the last 6 months:

- ☐ Taking care of personal grooming needs
- ☐ Taking care of children or others
- ☐ Enjoyment of hobbies
- ☐ Enjoyment of work
- ☐ Getting along with spouse/partner
- ☐ Getting along with co-workers & others
- ☐ Preparing meals for family/self
- ☐ Meeting financial obligations
- ☐ Meeting "home" responsibilities
- ☐ Meeting "work" responsibilities
- ☐ Getting along with children

Current Life Stressors

- ☐ Relationship issues (arguments, separation, divorce)
- ☐ Financial (owe money, loss of job, unemployment)
- ☐ Legal difficulties (law suit, traffic, criminal charges)
- ☐ Health issues (illness or injury)
- ☐ Abuse (physical, mental, emotional, sexual)
- ☐ Substance abuse (alcohol/drugs/food)

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
Not difficult _______ Somewhat difficult ______ Very difficult ______ Extremely difficult ________

Social Relationships

Please list family members:

Name	Relationship to You	Age	Living with You?

Please answer the following questions:

☐ Yes ☐ No Is there any history of violence, verbal or sexual abuse in your family?
☐ Yes ☐ No Have you ever been physically abused?
☐ Yes ☐ No Have you ever been sexually abused?
☐ Yes ☐ No Have you ever experienced or witnessed a traumatic event (accidents, crime, major medical illness)?

If yes to any of the questions above, please elaborate with your counselor.

Family History

☐ Yes ☐ No Has any family member ever had a problem with drugs and/or alcohol? If so, who and what?

____

☐ Yes ☐ No Has any member of your family ever had any history of depression, anxiety, or other mental problems? Any history of suicide?

____

____

Please describe any additional family stressors (e.g., financial, marital, illness) that may be contributing to your problems: ____

____

Counseling/Prior Treatment History

Have you received therapy/counseling in the past? Yes ☐ No ☐

If yes, what was helpful? ____

What would you have liked to be different? ____

Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations

Dates	Reason	Counselor's /Doctor's Name

☐ Yes ☐ No ☐ Never 1. Do you have thoughts about suicide now?
☐ Yes ☐ No ☐ Never 2. Have you ever thought about suicide?
☐ Yes ☐ No ☐ Never 3. Have you ever attempted suicide?
☐ Yes ☐ No ☐ Never 4. Do you have access to guns/weapons?

☐ Yes ☐ No ☐ Never 1. Are you thinking about hurting someone now?
☐ Yes ☐ No ☐ Never 2. Have you ever thought about hurting someone else?
☐ Yes ☐ No ☐ Never 3. Have you ever hurt someone else?

Medical/Physical Health

List any current health concerns____

____

Primary Medical Doctor ____

Date of Last Physical _______________ Blood Panel Taken? Yes ☐ No ☐

Describe any head injuries ____

Please check below if you have had any of the following medical conditions:

☐ Arthritis
☐ Stomach Ulcers
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Problems
☐ Colitis/Crohn's
☐ Chronic Pain
☐ Lupus
☐ Tuberculosis

☐ Diabetes
☐ Head Injury/Concussion
☐ Seizures
☐ Heart Attack
☐ Angina
☐ High Blood Pressure
☐ Urinary Retention
☐ Migraines
☐ Chronic Headaches

☐ PMS
☐ Asthma
☐ Other Respiratory Problems
☐ Cancer
☐ Menstrual Problems: _______________
____
☐ Pregnancy __________ times
☐ Miscarriage __________ times
☐ Surgery:

☐ Hysterectomy

____

____

Please List all current medications: (use the back of this form if necessary)

Medication Name	Dose	Purpose

Please list all PREVIOUS psychotropic medication you have EVER taken:

Medication Name	Dose	Purpose

Medication Allergies: ☐ No ☐ Yes (Describe: ____)

Please answer the following questions:

Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ Never (Skip to next section)
If yes, how many alcoholic drinks do you have in the average?
day _____________, week _____________, year ______________

If yes to the above, please answer the following:

☐ Yes ☐ No Have you ever sought help for alcohol or drug use (including AA or NA meetings)?

☐ Yes ☐ No In the past year, have you ever drank alcohol or used drugs more than you meant to? or have you spent more time drinking or using than you intended to?

☐ Yes ☐ No Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?

☐ Yes ☐ No Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?

☐ Yes ☐ No Has anyone ever objected to your drinking or drug use?

☐ Yes ☐ No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?

☐ Yes ☐ No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?

☐ Yes ☐ No Has your drinking or drug use ever caused legal problems (DUI's, traffic accidents, violence, etc.)?

Check if you have taken any of the following drugs: ☐ Yes ☐ No ☐ Never (Skip to next section)

☐ Marijuana / Pot
☐ Cocaine /Crack
☐ Inhalants
☐ Amphetamines/Speed
☐ Barbiturates/Sedatives/Downers
☐ Designer Drugs, Ecstasy
☐ Heroin/Opiates
☐ Intravenous Drug Use
☐ Tranquillizers (Xanax, Valium)
☐ PCP/ Angel Dust
☐ Pain Medicine
☐ LSD/ Hallucinogens

☐ Yes ☐ No Have you ever taken prescribed medication inappropriately?

Sleep Difficulties (Check all that apply):

☐ None	☐ Nightmares	☐ Snores
☐ Falling asleep	☐ Wets bed	☐ Stops breathing during sleep
☐ Falling back to sleep	☐ Walks in sleep	☐ Falls asleep when emotional
☐ Tired upon waking	☐ Early morning awakening	☐ Bad dreams

Usually, the time that I …….Go to bed: __________ AM ____________ PM
Wake up: __________ AM ____________ PM

Smoking: ☐ None Packs per day ________________ Age began: ____________

Caffeine (cups per day) Are you sensitive to caffeine? ☐ Yes ☐ No

Coffee: ☐ 1 ☐ 2 ☐ 3 ☐ 4 More ☐

Tea: ☐ 1 ☐ 2 ☐ 3 ☐ 4 More ☐

Soda/other: ☐ 1 ☐ 2 ☐ 3 ☐ 4 More ☐

Development

Did you have any major illnesses, injuries, accidents, or surgeries growing up?
(If yes to any of these, please describe) ____

____

____

Are there special, unusual, or traumatic circumstances that affected your development?
Yes ☐ No ☐ If yes, please describe

Comments regarding Childhood Development ____

____

____

____

Leisure/Recreation

What do you do in your free time? Describe special areas of interest or hobbies

____

____

Spiritual/Religious

How important to you are spiritual matters? ___ Not at all ___ A Little ___ Moderate ___ A Lot

Are you affiliated with a spiritual or religious group? Yes ☐ No ☐ (if yes, describe)

____

Would you like your spiritual/religious beliefs incorporated into counseling? Yes ☐ No ☐

(If yes, describe) ____

What are your personal strengths?

____

____

What helps you cope during this time?

____

____

Is there any additional information that would assist me in understanding your concerns or problems?

____

____

What are your goals for therapy? ____

____

____

I certify that all information above is true and accurate.

____ ___________________

Signature of Client, Parent or Guardian Date