

Personal History/Background Information—Adult (18+)

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

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

Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the 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
 Other mental health concerns (specify): _____

Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___
_____	_____	_____	___	___	___	___

Marital Status (more than one answer may apply)

Single Divorce in process Unmarried, living together
Length of time: _____ Length of time: _____
 Legally married Separated Divorced
Length of time: _____ Length of time: _____ Length of time: _____
 Widowed Annulment
Length of time: _____ Length of time: _____ Total number of marriages: ____
Assessment of current relationship (if applicable): Good Fair Poor

Parental Information

Parents legally married Mother remarried:
Number of times: _____
 Parents have ever been separated Father remarried: Number of times: _____
 Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? Yes No

If Yes, please describe: _____

Has there been history of child abuse? Yes No

If Yes, which type(s)? Sexual Physical Verbal

If Yes, the abuse was as a: Victim Perpetrator

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

Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

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 Friendly Leader Outgoing Shy/withdrawn Submissive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

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? Yes No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? Yes No

If Yes, describe: _____

Cultural/Ethnic

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

Are you experiencing any problems due to cultural or ethnic issues? Yes No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ___ Yes ___ No

If Yes, describe: _____

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

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

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

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Court violations: ___ Yes ___ No

DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No

Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information. _____

Charges	Date	Where (city)	Results
_____	_____	_____	_____

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? ___ Yes ___ No

___ High school grad/GED

___ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

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

Employment

Begin with most recent job, list brief job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: ___ FT ___ PT ___ Temp ___ Laid-off ___ Disabled ___ Retired

___ Social Security ___ Student ___ Other (describe): _____

Military

Military experience? ___ Yes ___ No Combat experience? ___ Yes ___ No
Where: _____
Branch: _____ Discharge date: _____
Date drafted: _____ Type of discharge: _____
Date enlisted: _____ Rank at discharge: _____

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?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

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

List any current health concerns: _____

List any recent health or physical changes: _____

Medical

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

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

Are you allergic to any medications or drugs? Yes No

If Yes, describe: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

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

- Sleep patterns Eating patterns Behavior Energy level
 Physical activity level General disposition Weight Nervousness/tension

Describe changes in areas in which you checked above: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Lunch	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Dinner	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High
Snacks	___ / week	_____	<input type="checkbox"/> No	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High

Comments: _____

Sleep

What time do you go to bed? _____ (weekdays) _____ (weekends)

What time do you awaken each morning? _____ (weekdays) _____ (weekends)

On average number of hours sleeping at night? _____

On average number of hours sleeping during the day? _____

Do you awaken during the night? _____ (yes/no)

If so, please specify how many times (on average) per night and typical duration of each awakening;

_____ (number of times per night) _____ (duration of usual awakening)

Family Health History

Have any of the following diseases occurred among the child's blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

___ Allergies

___ Deafness

___ Muscular Dystrophy

___ Anemia

___ Diabetes

___ Nervousness

___ Asthma

___ Glandular problems

___ Perceptual motor disorder

___ Bleeding tendency

___ Heart diseases

___ Mental Retardation

___ Blindness

___ High blood pressure

___ Seizures

___ Cancer

___ Kidney disease

___ Spinal Bifida

___ Cerebral Palsy

___ Mental illness

___ Suicide

___ Cleft lips

___ Migraines

___ Other (specify): _____

___ Cleft palate

___ Multiple sclerosis

Comments re: Family Health: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
					_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____	_____	_____	_____
Barbiturates	_____	_____	_____	_____	_____	_____	_____	_____
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	_____
Marijuana	_____	_____	_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	_____
Inhalants	_____	_____	_____	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____	_____	_____	_____
Nicotine	_____	_____	_____	_____	_____	_____	_____	_____
Over the counter	_____	_____	_____	_____	_____	_____	_____	_____
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	_____
Other drugs	_____	_____	_____	_____	_____	_____	_____	_____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

___ Addicted ___ Build confidence ___ Escape ___ Self-medication

___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes ___ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___ Yes ___ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Have drugs or alcohol created a problem for your job? ___ Yes ___ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

<input type="checkbox"/> Aggression	<input type="checkbox"/> Elevated mood	<input type="checkbox"/> Phobias/fears
<input type="checkbox"/> Alcohol dependence	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Recurring thoughts
<input type="checkbox"/> Anger	<input type="checkbox"/> Gambling	<input type="checkbox"/> Sexual addiction
<input type="checkbox"/> Antisocial behavior	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Sexual difficulties
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Sick often
<input type="checkbox"/> Avoiding people	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Sleeping problems
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Cyber addiction	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Thoughts disorganized
<input type="checkbox"/> Disorientation	<input type="checkbox"/> Judgment errors	<input type="checkbox"/> Trembling
<input type="checkbox"/> Distractibility	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Withdrawing
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory impairment	<input type="checkbox"/> Worrying
<input type="checkbox"/> Drug dependence	<input type="checkbox"/> Mood shifts	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Panic attacks	_____

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 goals for therapy? _____

Do you feel suicidal at this time? ___ Yes ___ No

If Yes, explain: _____
