



**Personal History – Adult (18+)**

Client's name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ 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., brother, sisters, grandparents, step relatives, half relatives. Please specify relationship.)



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**

Traffic 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.

<u>Charges</u>	<u>Date</u>	<u>Where (city)</u>	<u>Results</u>
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
\_\_\_\_\_

**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 job history: \_\_\_\_\_

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

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?
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**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: \_\_\_\_\_

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

- |  |  |                                   |  |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> Sleep patterns          | <input type="checkbox"/> Eating patterns     | <input type="checkbox"/> Behavior | <input type="checkbox"/> Energy level        |
| <input type="checkbox"/> Physical activity level | <input type="checkbox"/> General disposition | <input type="checkbox"/> Weight   | <input type="checkbox"/> Nervousness/tension |

Describe changes in areas in which you checked above: \_\_\_\_\_

**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 of preference

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

**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): \_\_\_\_\_

Does your body temperature change when you drink? \_\_\_ Yes    \_\_\_ No

If Yes, 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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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Do you feel suicidal at this time? \_\_\_ Yes \_\_\_ No

If Yes, explain: \_\_\_\_\_

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**FOR STAFF USE**

Therapist's signature/credentials: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Supervisor's comments: \_\_\_\_\_

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\_\_\_\_\_ Physical exam: \_\_\_ Required \_\_\_ Not required

Supervisor's signature/credentials: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
(Certifies case assignment, level of care and need for exam)