



### Personal History Form

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Gender: F \_\_\_ M \_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (work): \_\_\_\_\_ ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Method of Contact: \_\_\_\_\_

Person responsible for bill: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ May we send statements to this email or the above email? Yes or No

### Family Members Living in the Household

Relationship	Name	Age	Phone (If Applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Medical/Physical Health

Primary Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

List any current health concerns: \_\_\_\_\_

\_\_\_\_\_

List any recent health or physical changes: \_\_\_\_\_

\_\_\_\_\_

Please list any head injuries/TBI: \_\_\_\_\_

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

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

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

**Marital Status (more than one answer may apply)**

\_\_\_\_ Single    \_\_\_\_ Married    \_\_\_\_ Separated    \_\_\_\_ Divorce in Process    \_\_\_\_ Divorced (Date: \_\_\_\_\_)  
\_\_\_\_ Unmarried, living together    Total marriages: \_\_\_\_\_

Assessment of current relationship (if applicable):    Good    Fair    Poor

**Legal**

Are you involved in any active cases (traffic, civil, criminal)    \_\_\_\_ Yes    \_\_\_\_ No

If Yes, please describe: \_\_\_\_\_

\_\_\_\_\_

**Education**

Fill in all that apply: Years of education: \_\_\_\_\_ Currently enrolled in school? Yes \_\_\_\_ No \_\_\_\_

Other training: \_\_\_\_\_

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

**Employment**

Currently:    \_\_\_\_ FT    \_\_\_\_ PT    \_\_\_\_ Temp    \_\_\_\_ Laid-off    \_\_\_\_ Disabled    \_\_\_\_ Retired

\_\_\_\_ Social Security    \_\_\_\_ Student    \_\_\_\_ Other (describe): \_\_\_\_\_

\_\_\_\_\_

## Chemical use History

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

Yes  No If yes, describe: \_\_\_\_\_

\_\_\_\_\_

## Medication

Current prescribed medications	Dose	Dates	Purpose	Side Effects
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication allergic reactions: \_\_\_\_\_

## Prior Counseling Experiences

Psychiatric Treatment:  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_

Reaction or Overall Experience: \_\_\_\_\_

\_\_\_\_\_

Counseling:  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_

Reaction or Overall Experience: \_\_\_\_\_

\_\_\_\_\_

Suicidal thoughts/attempts:  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_

Reaction or Overall Experience: \_\_\_\_\_

\_\_\_\_\_

Drug/Alcohol Treatment:  Yes  No

When: \_\_\_\_\_ Where: \_\_\_\_\_

Reaction or Overall Experience: \_\_\_\_\_

\_\_\_\_\_

**Hospitalizations:** \_\_\_ Yes \_\_\_ No

When: \_\_\_\_\_ Where: \_\_\_\_\_

Reaction or Overall Experience: \_\_\_\_\_

\_\_\_\_\_

**Do you feel suicidal at times?** \_\_\_ Yes \_\_\_ No

Do you/Have you had suicidal thoughts ? Plans? Attempts? Is so, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_ Aggression \_\_\_ Elevated Mood \_\_\_ Fears \_\_\_ Alcohol Dependence \_\_\_ Feeling Tired

\_\_\_ Recurring Thoughts \_\_\_ Anger \_\_\_ Gambling \_\_\_ Sexual Addiction \_\_\_ Sick Often

\_\_\_ Feelings of Sadness \_\_\_ Hallucinations \_\_\_ Sexual Difficulties \_\_\_ Anxious/Worried

\_\_\_ Heart Palpitations \_\_\_ Avoiding People/Places \_\_\_ High Blood Pressure \_\_\_ Sleep Problems

\_\_\_ Chest Pain \_\_\_ Feelings of Hopelessness \_\_\_ Speech Problems \_\_\_ Breathlessness

\_\_\_ Impulsivity \_\_\_ Suicidal Thoughts \_\_\_ Loss of Interest \_\_\_ Irritability \_\_\_ Disorientation

\_\_\_ Thoughts I Can't Control \_\_\_ Judgement Errors \_\_\_ Trembling \_\_\_ Difficulty Concentrating

\_\_\_ Loneliness \_\_\_ Withdrawing \_\_\_ Dizziness \_\_\_ Forgetful \_\_\_ Repeated Checking

\_\_\_ Drug Dependence \_\_\_ Mood Shifts \_\_\_ Eating Disorder \_\_\_ Panic Attacks

\_\_\_ Other (specify): \_\_\_\_\_

\_\_\_\_\_

**Briefly discuss how the above symptoms impair your ability to function effectively:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Additional information that would assist me in understanding your concerns or problems:** \_\_\_\_\_

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**Describe your support system:** \_\_\_\_\_

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**What are your goals for therapy?** \_\_\_\_\_

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\_\_\_\_\_

**Signature**

\_\_\_\_\_

**Date**