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

_____

_____

_____

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: _____

_____

_____

_____

_____

_____

Describe your support system: _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**