741 Volare Drive, Birmingham, AL 35244
205-732-5072

PERSONAL HISTORY – ADULT

Client's Name: ____ Date: _____________
Gender: ____________________ Date of Birth: ________________ Age: ____________
Form completed by (if someone other than client): ____
Address: ____ City: ____________________ Zip: ________
Phone (home): __________________________________ Work: _______________________________
Emergency contact name: ____
Emergency contact number: ____

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
_____ Fear/phobias _____ Sleep ____ Divorce _____ Relationships
_____ Coping skills _____ Chronic Pain ____ Behavioral issues _____ Grief
_____ Infidelity _____ Domestic Abuse ____ Family conflict _____ Parenting
_____ Life transitions _____ Life coaching ____ Marital _____ Pre-marital
_____ Self -esteem _____ Co-dependency ____ personality _____ peer relationship
_____ stress management _____ Trauma/PTSD ____ Women's issues _____ Chronic illness
_____ Other (please explain): ____
____
____

FAMILY INFORMATION:

Relationship	**Name**	**Age**	**Living**	**Living with you**
Mother	______________________________	______	Yes or No	Yes or No
Father	______________________________	______	Yes or No	Yes or No
Spouse	______________________________	______	Yes or No	Yes or No
Children	______________________________	______	Yes or No	Yes or No
	______________________________	______	Yes or No	Yes or No
	______________________________	______	Yes or No	Yes or No
	______________________________	______	Yes or No	Yes or No

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

Relationship	Name	Age	Living	Living with you
________________	________________________	_______	Yes or No	Yes or No
________________	________________________	_______	Yes or No	Yes or No
________________	________________________	_______	Yes or No	Yes or No
________________	________________________	_______	Yes or No	Yes or No
________________	________________________	_______	Yes or No	Yes or No
________________	________________________	_______	Yes or No	Yes or No
________________	________________________	_______	Yes or No	Yes or No

Marital Status (more than one answer may apply)
_____ Single _____Divorced _____ Divorce in Progress _____Unmarried
_____ Legally married _____ Separated _____ Unmarried, living together
_____ Engaged _____ Student

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

Parental Information:

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

Special circumstances (e.g., raised by person other than biological 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
Other childhood issues: ____ Verbal abuse _____ 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/Withrawn ____ Submissive ____ Other: specify ______________________________

Sexual orientation: _________________________ Comments: __________________________________
Sexual dysfunctions: ______ Yes _______ No
If Yes, describe: ____
____

CULTURAL/ETHNIC

Are there any cultural or spiritual beliefs that may conflict with treatment? _____ Yes _____ No
If Yes, please explain: ____
____
____
____

LEGAL

Current Status:

Are you involved in any active cases (traffic, civil, criminal, etc…)? ______ Yes _______ No
If Yes, please describe and indicate the court and hearing/trial dates and charges: __________________
____
____
____
____

Are you presently on parole or probation? _____ Yes _______ No
If Yes, please describe: ____
Any current or history of being a sexual perpetrator? ______ Yes _______ No
If Yes, 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:

Charges:	Date:	Where:	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 job history:

Employer	Dates	Title	Reason left the job
________________________	____________	__________	________________________________
________________________	____________	__________	________________________________
________________________	____________	__________	________________________________
________________________	____________	___________	________________________________
________________________	____________	___________	________________________________
________________________	____________	___________	________________________________

Currently: ____ FT ____ PT ____ Temp ____ Laid Off ____ Disabled ____ Retired
____ Social Security ____ Student ____ Other: ____________________________

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

(Please list all current diagnosis and meds)

Diagnosis:	When?	Current symptoms?

____
____
____
____
____

Please list current medications.

____
____
____
____
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____

Please list any past mental health diagnosis and/or past psychiatric hospitalizations.

____
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____
____
____

COUNSELING/PRIOR TREATMENT HISTORY

Information about client (past and present):

Counseling/Psychiatric treatment YES OR NO If Yes, When and Where? ______________________
____
Your reaction to past counseling/psychiatric treatment? _________________________________
____

Suicidal Thoughts/attempts? YES OR NO If Yes, please explain: ___________________________
____
____

Drug/Alcohol Treatment? YES OR NO If Yes, please explain: ______________________________
____
____
____

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

Aggression	Elevated Mood	Phobias/Fears	Alcohol Dependence
Fatigue	Recurring Thoughts	Anger	Gambling
Sexual Addiction	Antisocial Behavior	Hallucinations	Sexual difficulties

Anxiety	Heart palpitations	Sick often	Avoiding people
High blood pressure	sleeping problems	Chest pain	Hopelessness
Speech problems	impulsivity	Suicidal Thoughts	Depression
Irritability	Thoughts disorganized	Disorientation	Judgment errors
Trembling	Distractibility	Loneliness	Withdrawing
Dizziness	Memory Impairment	Worrying	Drug dependence
Mood shifts	Eating disorder	Panic Attacks	Other: ____________________

Briefly discuss how the above symptoms and/or your current issues impair your ability to function effectively.

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Any additional information that would assist us in understanding your concerns or problems? _________

____
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____

What are your goals for therapy? ____

____
____
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____
____
____

FOR STAFF USE

Therapist's signature/credentials: ____ Date: _________

Referrals?: ____

____
____
____