Pittsburgh Pastoral Institute

PERSONAL HISTORY FORM

Name _____ Date _____

Sex _____ Date of Birth _____ Social Security Number _____

Address _____ ZIP _____

Phone (Home) _____ Emergency Contact (person) _____
(Work) _____ (phone) _____

Single _____
Married ___ date _____
Widowed ___ date _____
Divorced ___ date _____
Separated ___ date _____
Living Together ___ date _____

Dates of Previous Marriages:
sep. div. wid.
1._____
2._____
3._____

Persons currently living with you in your home (name, age, and relationship): _____

_____

_____

Immediate family members living elsewhere (name, age, and relationship): _____

_____

_____

Family History Information

Name _____ Name _____

Age _____ Age _____

Occupation _____ Occupation _____
If deceased, date and cause of death: If deceased, date and cause of death:

_____ _____

Stepparents (name, age, relationship, occupation) _____

_____

Siblings/Stepsiblings (name, age, relationship) _____

_____

Educational & Vocational History

Education (highest level completed and date**)** _____

Additional education or vocational training since high school (dates, schools, programs, degrees, certificates, etc.)

_____

_____

Current Occupation/Employer: _____
Full-time ____ Part-time ____ Temporary ____ Unemployed ____ Disabled ____ Retired ____ Student ____
Homemaker ____ Other _____

Previous Occupations (last three employers)**:** _____

_____

Military Service (dates and branch) _____

Medical History: That would be helpful for therapy

Personal Health Concerns: _____

_____

Family Health Concerns: _____

_____

Are you currently taking any medications? No ____ Yes (type and amount) _____

_____

Primary Care Physician Information:

Name _____ Phone _____

Address _____

Height _____ Weight _____

Do you have any relevant allergies? No ____ Yes (specify) _____

Do you smoke? No ____ Yes (how much) _____

Alcohol use? No ____ Yes (what / how much) _____

Caffeine use? No _____ Yes (how much) _____

Legal Issues

Please note any past or present legal issues or problems (including dates and current status) _____

_____

_____

Therapeutic Background

Have you had previous therapy? No ____ Yes (name of therapist(s), date(s), and outcomes) _____

_____

_____

Have you been hospitalized for psychiatric treatment? No ____ Yes (specify hospital(s), date(s), and outcomes)

_____

Do you have any suicidal or homicidal thoughts at the present time? No ____ Yes ____
If yes, do you have any suicidal or homicidal plans? No ____ Yes ____
If yes, do you intend to carry out your plans? No ____ Yes ____

Present Concerns

Briefly note the concerns that bring you to therapy and the results you hope to achieve _____

_____

_____

_____

_____

If applicable, note your religious denomination/affiliation and any spiritual/religious concerns you want to discuss

_____

_____

_____

Any Additional Comments or Concerns:

_____

_____

_____

Signature _____ **Date** _____