Christian Counseling Centers of Oregon
Personal History Inventory

Please fill out this form and bring it with you to your first session. All provided information will be protected as a confidential document.

Contact Information

Name: _____ Birth date: _____ Age: _____

Parent/Guardian (If under 18 years old): _____

Current Address: _____

Apartment or Box #:_____ City: _____ State:_____ Zip:_____

Home Phone: _____ Is it ok to leave a message? Yes [ ] No [ ]

Cell/Other Phone: _____ Is it ok to leave a message? Yes [ ] No [ ]

Email: _____ Is it ok to e-mail you? Yes [ ] No [ ]

What is your preferred way for me to contact you? _____

Emergency Contact Name*: _____ Phone: _____
*This person will only be contacted in case of an emergency. By giving their contact information, you are authorizing me to break confidentiality of our relationship.

Referred by (if any):_____

Relationships

Marital Status: Never Married [ ] Domestic Partnership [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ]

If married or living with a domestic partner, how long? _____

If divorced or currently separated, how long? _____

If widowed, how long? _____

If not married or living with a partner, are you dating? Yes [ ] No [ ] If no, is this by choice? Yes [ ] No [ ]

Spouse/Partner's Name (if applicable):_____

Is your spouse/partner supportive of you seeking counseling? Yes [ ] No [ ] If no, explain: _____

_____

On a scale of 1-10 (10 being great), how would you rate your current relationship? _____

Are you currently experiencing any sexual difficulty or do you have any sexually-related issues you would like to discuss in therapy?

Do you have children? If so, please list their names and ages:

Current
Please describe your reasons for seeking counseling at this time:

How long have these issues been of concern to you?

What do you hope to happen by coming to counseling?

Please circle any that are a concern for you:

depression /sadness
anxiety / worry / stress
sleeping habits
eating habits / physical appearance
physical illness
sexual identity / sexual performance
anger
relationships
abusive situation
family issues
school performance
substance abuse
spiritual issues
making decisions
poor self-esteem
career / life goals
phobias / fears
suicidal
crying/emotions
loneliness
work

Family of Origin
Please list names/ages of any immediate family members that are still living (father, mother, siblings):

Is there a family member you feel you most identify with?

How would you describe your childhood?

Please circle any of the following that describes your family/home atmosphere as you were growing up:

Alcoholism
Affectionate
Angry
Close
Cold
Competitive
Distant
Emotional Abuse
Fighting
Frightening
Mental Illness
Relocating Excessively
Neglectful
No Fun
Overprotective
Physical Abuse
Physical Illness
Poverty
Prejudice
Rigid
Sexual Abuse
Stable
Supportive
Trusting
Other:

Please circle any of the following that your family members currently battle. Please identify their relationship to you (i.e. mother, brother, aunt, grandparent etc.)

Alcohol/Substance Abuse
Anxiety
Bipolar
Depression
Domestic Violence
Eating Disorders
Obesity
Obsessive Compulsive Behavior
Schizophrenia
Suicide Attempts
Other:

Social
Who would you consider to be your closest friend? Please describe your friendship:

Are you satisfied with your current social life? Please explain:

Are you involved with any social groups, churches, activities, hobbies, sports teams, etc.?

Employment
Are you currently employed? Yes [ ] No [ ] If yes, where is your place of employment and how long have you been there?

Is there anything stressful about your current place of employment?

If you are unemployed, how long and what did you do prior to unemployment?

Education
What is your highest level of education?

If you are currently a student, what is your grade or major?

Have you ever been diagnosed with a learning disability? If so, please explain:

General Health
Current Physician: _____ Phone: _____

List all medications (prescription and psychiatric) including the dosage and strength:

How would you describe your physical health?

Do you exercise and if so how often?

Have there been any changes in your current sleeping habits?

Have there been any changes in your daily eating habits?

Do you drink alcohol? Yes [ ] No [ ] If yes, please describe your alcohol intake.

Do you engage in recreational drug use? Yes [ ] No [ ] If yes, please describe.

Any other medical concerns you would like to discuss in counseling?

Mental Health
Have you ever met with a counselor before? Yes [ ] No [ ] If yes, please describe this experience.

Have you ever attempted suicide? Yes [ ] No [ ] If yes, describe the situation.

Please indicate your general mood level for the last month by circling a number below:

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
suicidal depressed down average happy ecstatic

Please indicate your current level of anxiety over the last month by circling a number below:

1 2 3 4 5 6 7 8 9 10
peaceful uneasy worried panicky

Spiritual
Do you consider yourself a spiritual or religious person? If yes, please describe your faith/spirituality and when did you develop your current beliefs?

Do your family and friends share your beliefs? Yes [ ] No [ ] If they do not, please give a brief explanation.

Have you found your spiritual beliefs to be helpful or a hindrance?

Personal
How would you describe your personality?

What would you define as your greatest strengths?

What are some areas of growth you would like to see developed in your life?

How would you complete the following sentence about your life? Allow this to be a creative outlet for you to describe yourself.

"Once upon a time there was a _____ and…."

Is there anything else you would like for me to know about you?