# Personal History Questionnaire

This questionnaire is intended to help your clinician review general information quickly so that your session with her can focus on the concerns, which led to your scheduling this appointment. Feel free to leave blank any questions which do not apply or which you prefer not to answer in this format. I will follow-up with you for additional information pertaining to some items on this form. This form will be held in confidence as part of your patient record in this office.

**NAME**: ______________________________ **BIRTHDATE:** _________________ **DATE**: ___________________

**Please Summarize Your Reasons for Seeking Services at This Time**

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

---

**EDUCATIONAL HISTORY**

What is your last grade completed or degrees earned? _____________________________________________

During school do or did you receive any: ____ Special education? ____ Tutoring? ______ Alternative Schooling?

Have you ever served in the military? _______ Yes________ No If yes, please answer the following:

Dates of service: _____________ Type of Discharge: ____________ Combat experience? ____________

---

**VOCATIONAL HISTORY (if applies)**

What is your current occupation? ______________________________________________________________________

How long have you been employed in your present position? ___________________

Since becoming an adult, how many different jobs have you held? _______________

Have you had any periods of unemployment, which lasted four months or longer? _____Yes _____No

If yes, please describe circumstances briefly: ______________________________________________________________

Have you made any career changes? _______ Yes _______ No

If yes, what was/were your previous occupations? ___________________________________________________________

Are you satisfied with your current job? _____Yes _______No

Have there been any major changes in your current work situation during the past year? ______Yes ______No

If yes, please describe: ________________________________________________________________________________

**MEDICAL HISTORY**

Please list all medications you are currently taking, including dosages if you know them:

| Medication | Dosage | Prescribed By |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Current Medical Doctor _______________________________________________ Phone No. ______________________

Have you ever had major surgery? ________Yes _________No

Have you ever had a head injury, which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion or behavior? _________Yes _________No

Have you ever had an extremely high fever (greater than 103˚ F)? _________Yes __________No

Have you ever fainted or had a seizure? _________Yes __________No

Do you have any medication allergies or sensitivities? __________Yes __________No

If yes, please specify: ____________________________________________________________

Do you have any food, animal or seasonal allergies or sensitivities? __________Yes ___________No

If yes, please specify: ___________________________________________________________________________

Do you regularly engage in physical exercise? ___________Yes____________No

Do you, or have you in the past, regularly used cigarettes ___________Yes____________No

Please list any other medical conditions or concerns: _________________________________________________________

---

## PSYCHOLOGICAL TREATMENT HISTORY

Have you every taken medication for psychological/psychiatric reasons? _______Yes _______No

If yes, please indicate when, and what conditions/problems: ____________________________________________________

______________________________________________________________________________________________

Have you received counseling or psychotherapy previously? ________Yes _______No

If yes, please indicate when, and by whom: __________________________________________________________

Have you ever been hospitalized for psychological/psychiatric reasons? ________Yes ________No

Has anyone in your family (parents, grandparents, siblings, other relative) been diagnosed and/or treated for psychological/psychiatric condition(s)? _________Yes _________No

**ALCOHOL/DRUG HISTORY** (if applicable)

If you drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequency:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

If you have used, or currently use any street drugs, please describe which ones and your pattern(s) of use:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever tried to cut down on your use of alcohol or drugs? _________Yes _________No

Has anyone gotten angry with you because of your alcohol or drug use? _________Yes _________No

Have you ever felt guilty or worried about your use of alcohol or drugs? ________Yes _________No

Have you ever received outpatient alcohol / drug treatment or detoxification services? _____Yes ______No

Have you ever received inpatient alcohol / drug treatment or detoxification services? _____Yes ______No

Has anyone in your family had a problem with alcohol or drugs? _________Yes _________No

---

**LEGAL HISTORY**

Please check all legal actions or proceedings you have been a part of:

_____ Arrests/assaults _____ Arrests/other ______ DUI(how many?_____)

_____ Restraining/protective order(s) _____ Child Protective Services _____ Divorce/custody

_____ Disability claim(s) Other (describe) ________________________________________________

---

**PERSONAL INFORMATION**

Have you experienced a loss (death, divorce, or significant situational losses) with the past 24 months?

_________Yes __________No

Did you experience any losses (as described above) during childhood or adolescence?

_________Yes __________No

If yes, please indicate whom, and your age at the time of loss: ___________________________________

Have you relocated or changed jobs within the past 24 months? __________Yes ___________No

How many siblings do you have, and what is your birth order among them? ________________________

Were you adopted or separated from your birth parents during childhood? _________Yes __________No

Were your parents divorced (if yes, please indicate your age at the time of their separation?) _____ Yes _____ No ______

Please indicate your parent's current ages, or their ages at the time of their deaths: ________________________________

Has religion or spirituality played an important role in your life? __________Yes ___________No

Do you own or have access to firearms? __________Yes ___________No

Describe your developmental history (Were there any pregnancy complications? Did your mom use drugs or alcohol while pregnant? Were there any complications w/your birth and delivery? Anything else you'd like to add about your development)

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**Thank you for taking time to complete this questionnaire. Its purpose is to gather general information – I will follow up in more detail as appropriate. Please use this space below to provide any additional information that you think would be important for me to know. Also, please feel free to use the space below to describe your current goals for the services I will be providing.**

______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Your signature: ______________________________________________________________

Reviewed by: _____________________________________________ Date: ____________________
Clinician's signature