Personal History/Background Information

Client's name: ________________________________ Date: _______________

Gender: ____ F ____ M Date of birth (mm/dd/yyyy): _____________ Age: _________

Address: ___________________________ City: _______________ State: ______ Zip: __________

Phone (home): ______________________ (mobile): ________________ (work): __________________

Best number to call? mobile, home, work, no preference (circle one)

Is it okay to leave a message? Yes, No (circle one)

Email address: ____

Is it okay to send you an email message? Yes, No (circle one)

Emergency contact: ____ (indicate relationship to you)

Emergency contact's telephone and address: ____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

__ Anxiety ____ Depression ____ Coping ____ Anger

__ Obsessions/compulsions ____ Fear/phobias ____ Grief/loss ____ Sexual concerns

__ Sleeping problems ____ Perinatal/postpartum ____ Infertility ___ Intrusive thoughts

__ Other mental health concerns (specify): ____

Family Information

Relationship	Name	Age	Living: Yes	Living: No	Living with you: Yes	Living with you: No
Mother						
Father						
Spouse						
Children						

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

Relationship	Name	Age	Living: Yes	Living: No	Living with you: Yes	Living with you: No

Marital/Relationship Status (more than one answer may apply)

__ Single ___ Divorce in process ___ Unmarried, living together

__ Legally married ___ Separated ___ Divorced

__ Widowed ___ Annulment

Number of marriages: ____ Length of current relationship: _____

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

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 ____Verbal

If Yes, the abuse was as a: ____ Victim ____ Perpetrator

Other childhood issues: __ Neglect __Inadequate nutrition __ Other (please specify): _________

Comments re: childhood development: ____

____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

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/withdrawn ____ Submissive

__ Other (specify): ____

Sexual orientation: _________________ Comments: ______________________________

Sexual dysfunctions? ____ Yes __ No

If Yes, describe: ____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ______________________________

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes _______ No

If Yes, describe: ____

Other cultural/ethnic information: ____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? __ Yes ___ No

If Yes, describe: ____

Were you raised within a spiritual or religious group? ____Yes ___No

If Yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes __ No

If Yes, describe: ____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___No

If Yes, please describe____

____

Past History

Court violations: ____ Yes __ No   DWI, DUI, etc.: ____ Yes __ No

Criminal involvement: ____ Yes __ No   Civil involvement: ____ Yes __ No

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/present job, list brief job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____ FT ___ PT ____ Temp __ Laid-off ____ Disabled ___ Retired

__ Student ____ Other (describe):

Military

Military experience? ____ Yes ____ No   Combat experience? ___ Yes ____ No

Active duty? ____ Yes ___ No   Reserves? ____ Yes ____ No

Leisure/Recreational

Describe special areas of interest or hobbies

Activity	How often now?	How often in the past?

Medical/Physical Health

List any current health concerns: ____

List any recent health or physical changes: ____

____

Name of your primary care physician: ____

Name of your psychiatrist (if applicable): ____

Current prescribed medications	Dose	Dates	Purpose	Side effects
________________	_____	_______	__________	____________
________________	_____	_______	__________	____________
________________	_____	_______	__________	____________
________________	_____	_______	__________	____________

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
________________	_____	_______	__________	____________
________________	_____	_______	__________	____________

Are you allergic to any medications or drugs? ____ Yes __ No (please list) ________________

	Date	Reason	Results
Last physical exam	_______	______________	________________
Last doctor's visit	_______	______________	________________
Surgery	_______	______________	________________
Other medical	_______	______________	________________

____

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: ______________________________

____

Sleep

What time do you go to bed? _________ (weekdays) _________ (weekends)

What time do you awaken each morning? ________ (weekdays) _________ (weekends)

On average number of hours sleeping at night? _________

On average number of hours sleeping during the day? _________

Do you awaken during the night? _____ (yes/no)

If so, please specify how many times (on average) per night and typical duration of each awakening;

________ (number of times per night) _________ (duration of usual awakening)

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	___	___	___	___	___	___	___	___
Barbiturates	___	___	___	___	___	___	___	___
Valium/Librium	___	___	___	___	___	___	___	___
Cocaine/Crack	___	___	___	___	___	___	___	___
Heroin/Opiates	___	___	___	___	___	___	___	___
Marijuana	___	___	___	___	___	___	___	___
PCP/LSD/Mescaline	___	___	___	___	___	___	___	___
Inhalants	___	___	___	___	___	___	___	___
Caffeine	___	___	___	___	___	___	___	___
Nicotine	___	___	___	___	___	___	___	___
Over the counter	___	___	___	___	___	___	___	___
Prescription drugs	___	___	___	___	___	___	___	___
Other drugs	___	___	___	___	___	___	___	___

Substance Use Questions

Describe when and where you typically use substances: ______________________________

____

Describe any changes in your use patterns: ______________________________

____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

____

Reason(s) for use:

___ Addicted ____ Build confidence ____ Escape ____ Self-medication

___ Socialization ____ Taste ____ Other (specify): ______________

How do you believe your substance use affects your life? ______________________

Who or what has helped you in stopping or limiting your use? ______________________

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

___ Yes __ No If Yes, describe: ______________________________

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ___Yes ___No

If Yes, describe: ____

Have you had adverse reactions or overdose to drugs or alcohol? (describe):______________

____

Have drugs or alcohol created a problem for your job? ___ Yes __ No

If Yes, describe: ____

Counseling/Prior Treatment History

Information about yourself (past and present):

Counseling/Therapy: (start/end date, where, provider, overall experience):

____

____

____

____

	Yes	No	Where/When	Provider of treatment	Details
Suicidal thoughts/attempts	____	____	____________	__________________	________________
Drug/alcohol treatment	____	____	____________	__________________	________________
Hospitalizations	____	____	____________	__________________	________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	____________	__________________	________________

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

___ Aggression
___ Alcohol dependence
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug dependence
___ Panic attacks
____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Other (specify): _____________
____ Phobias/fears
____ Recurring thoughts
____ Sexual addiction
____ Sexual difficulties
____ Sick often
____ Sleeping problems
____ Speech problems
____ Suicidal thoughts
____ Thoughts disorganized
____ Trembling
____ Withdrawing
____ Worrying
____ Eating disorder

Family Mental Health History

Family history of (check any that apply and list relationship to you)

__________ Depression _________ Bipolar Disorder __________ Anxiety _______ Addiction

____ Other (please list)____

Family mental health treatment

	Yes	No	Who	When	Details
Counseling/Psychiatric	____	____	____________	__________________	________________
Suicidal thoughts/attempts	____	____	____________	__________________	________________
Drug/alcohol treatment	____	____	____________	__________________	________________
Hospitalizations	____	____	____________	__________________	________________
Involvement with self-help	____	____	____________	__________________	________________

Comments re: family mental health history: ______________________________________

Current Difficulties

Briefly discuss how your symptoms impair your ability to function effectively: ____________________
____
____
____
____

Any additional information that would assist us in understanding your concerns or problems: ________
____
____
____
____

What are your goals for therapy? ____
____
____
____
____

Any concerns about therapy? ____
____
____

Do you feel suicidal at this time? ____ Yes __ No