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Counselor, Consultant and Minister

PERSONAL HISTORY FORM

I. DEMOGRAPHIC INFORMATION

Client Name____ Date_______________________

Gender _______M _______F Date of Birth ________/________/___________ Age____________

Address_______________________________ City_________________ State_______ Zip_______________

Phone (Home)_____________________ (Work)____________________ (Cell)______________________

Referral Source_____________________________________ Payment Source___________________________

Is it ok to contact you at home? _____Y _____N Work?____Y _____N Cell? _______Y ________N

II. PRESENTING PROBLEMS

What prompted you to seek treatment? ____
____

How long has this been a problem for you? ____

How would you rate the severity of the problem today? __Mild __Moderate __Serious __Severe

How would you rate the severity of the problem 1 month ago? __Mild __Moderate __Serious __Severe

What specific symptoms/problems do you think are relevant to your treatment? Please check all that apply.

__ Relationship problems (peers or family)
__ Angry outbursts
__ Crying easily
__ Trouble concentrating
__ Fatigue or loss of energy
__ Depressed mood
__ Feelings of worthlessness
__ Thoughts of hurting yourself or others
__ Nightmares
__ Sleep disturbances
__ Aggressive behaviors
__ Financial stress
__ Academic problems
__ Odd behaviors or thoughts
__ Taking alcohol/drugs
__ Difficulty following directions
__ Abusive relationships
__ Change in appetite
__ Fears/phobias
__ Coping problems
__ Legal problems
__ Social withdrawal
__ Distrust
__ Rapid heart rate
__ Restlessness
__ Recent traumatic events
__ Unresolved childhood issues
__ Chest pains
__ Increased illnesses or medical problems
__ Problems at work
__ Stress
__ Parenting problems
__ Grief or loss issues
__ Other: ______________________________________

III. BIOPSYCHOSOCIAL

FAMILY INFORMATION

Family Information

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

Significant Others (Brothers, Sisters, Step-relatives, Half-relatives, Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No

Marital Status (more than one answer may apply)
_____ Single ______Married _______Divorced _______Separated

Assessment of Current Relationship (if applicable) ___ Good ___ Fair ___Poor
Please explain: ____
____

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

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

Strengths/support ____
Stressors/problems ____

DEVELOPMENT

Have you ever been abused as a child or an adult? _____ No _____Yes
If yes, which types of abuse? _____ Sexual _____ Physical _____ Verbal _____ Perpetrator _____Victim
If yes, was the abuse ever reported? _____ No _____Yes

Other childhood issues: ___ Neglect ___ Inadequate Nutrition ___ Medical Complications
Comments regarding childhood experiences: ____

____
____
____
____

SOCIAL RELATIONSHIPS

Check how you generally interact with friends and family members: (check all that apply)
_____ Lovingly _____ Fight/Argue _____ Get picked on _____ Try to avoid them
Other (specify) ____

How would you describe your personality? (check all that apply)
_____ Follower _____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn

Do you have a best friend now? _____ No _____ Yes In the past? _____ No _____ Yes

Sexual Orientation: ____________________ Comments: ________________________________

Strengths/support ____
Stressors/problems ____

CULTURAL / ETHNIC

From which cultural or ethnic group, if any, do you belong? ___________________________
Are you experiencing any problems due to cultural or ethnic issues? _____ No _____ Yes (describe) __________
____
Other cultural / ethnic information: ____
____

Strengths/support ____
Stressors/problems ____

SPIRITUAL / RELIGIOUS

How important to you are spiritual matters? _____ Not _____ Little _____ Moderate _____ Much
Are you affiliated with a spiritual or religious group? _________________________________
Were you raised within a spiritual or religious group? _____ No _____ Yes (describe) ______________
Would you like your spiritual/religious beliefs incorporated into the counseling?
_____ No _____ Yes (describe)____

Strengths/support ____
Stressors/problems ____

LEGAL

List all arrests (charges), dates of arrests, and the outcomes
____
____
____
Please describe any past or present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling, etc.) ____

Strengths/support ____

Stressors/problems ____

EDUCATIONAL

(CHILD/TEEN)
What grade are you in? ____________ What school do you attend? ________________________________
Academic Grades: *above average, average, below average, inconsistent*
Are you in Special Education Classes? _____ No _____ Yes (describe) ____________________________
Have you ever failed a grade? _____ No _____ Yes Which one(s)? ______________________________
How many schools have you attended? ___________

(ADULT)
Graduated from High School/GED? _____ No _____ Yes Year Completed? ___________
College: _____________ Major: _________________ Year Completed? ___________
Are you satisfied with your level of education? Explain: ______________________________________
____
Strengths/support ____
Stressors/problems ____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left the Job	How often miss work?

Strengths/support ____
Stressors/problems ____

MILITARY

Military Experience? _____ No _____ Yes Combat History? _____ No _____ Yes
Branch ____________________ Discharge Date ________________ Date Drafted ______________ Type of Discharge ___________ Date Enlisted __________________ Rank at Discharge ______________

Strengths/support ____
Stressors/problems ____

LEISURE / RECREATIONAL

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, church activities, diet/health, fishing, traveling, etc.)
____
____

Strengths/support ____
Stressors/problems ____

MEDICAL / PHYSICAL HEALTH

_____ Active Medical Problems ____ Past Hospitalizations _____ Current Medications
_____ Major Medical Illness _____ Other Medical Problems (describe) ______________________________
If "Yes," describe: ____

Do you currently have any medical problems that are not being treated by a doctor, but should be?
_____ No _____ Yes (describe) ____

List any family history of medical problems: ____
____

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

Describe changes marked above: ____
____
____

CHEMICAL USE HISTORY

Have you ever used any illegal drugs? _____ No _____ Yes (describe) ______________________
____

Do you drink alcohol? _____ No _____ Yes (describe frequency and amount) ______________________
____

Have any of your family members or significant relationships had a problem with drugs or alcohol?
_____ No _____ Yes (describe who and circumstances) ______________________________
____

Describe how drugs or alcohol have affected your life: ______________________________
____

COUNSELING / PRIOR TREATMENT HISTORY

Have you ever participated in any counseling/therapy services? _____ No _____ Yes (describe when/where)
____
____
Are you currently seeing another therapist? _____ No _____ Yes If so, who? ______________________
Have any of your family members or significant relationships been involved in counseling or treatment?
_____ No _____ Yes (describe) ____
____
Have you ever been hospitalized for drugs/alcohol/psychiatric care? _____ No _____ Yes (when/where)
____
____
Have you ever been involved in any self-help groups (AA, NA, Al-Anon, etc.)? _____ No _____ Yes
Which ones? ____
Have you ever attempted suicide or had suicidal thoughts? _____ No _____ Yes (describe)
____
____
Are you feeling suicidal now? _____ No _____ Yes

CLIENT OPINION ABOUT STRENGTHS AND NEEDS

What do you see as your own or your family strengths?

____
____
____
____
____
____

Is there any other information about you that you think is relevant for your treatment planning?

____
____
____
____
____
____

Please list one or more goals you would like to reach during the course of your treatment.

____
____
____
____
____
____

____ ______________
SIGNATURE OF PERSON COMPLETING THIS FORM DATE

____
RELATIONSHIP TO THE CLIENT