CONFIDENTIAL NOT TO BE RELEASED TO OTHERS WITHOUT WRITTEN CONSENT OF PATIENT

ADULT HISTORY

Patient's Name:____DOB:_____________________

Note: This personal history form is intended to help us work together. Everything is confidential. You may choose what to answer and what not to answer. Many questions can be answered by just writing yes or no or by making a check mark. Don't worry if you can't answer some of the questions, or if some do not apply to you. Just fill in the blanks as completely as you can. PLEASE FILL PRINT OR WRITE LEGIBLY.

Personal History

Age:_______________ Male Female How long in this state?_________ Country?______

Do you move often?____ Birthplace: ___________ Citizen of what nation/country?____________________

Raised primarily where?____________________

Is your… Father living? ________ Mother? ________ Married? _______ Divorced? _______ How long:___________

Was your family… Poor Average Wealthy

Language spoken at home: ____________________

Was your home life with parents/family of origin... Unhappy Bearable Pleasant Very Happy

Do you belong to a church/temple?_____

What denomination? _______________

How often do you attend?___________

Are you…

Single Engaged (How long?)_____ Married Widowed Separated Divorced

Is your current home life… Very Happy Pleasant Bearable Unhappy

Number of brothers:___________ Their ages ____

Number of sisters:_____________ Their ages:____

Father's name and occupation:____

Mother's name and occupation:____

Father's education:_________________________________ Mother's education:______________________________

Spouse's name:____________________________________ Age: ________

Spouse's work or chief interest:____

Do you have children?_________

Child(ren) Name(s) & Age(s):

Who lives in your home?

Current Symptoms, History of Behavioral/Mental Health Treatment & Psychotropic Medications

Please check all the behaviors and symptoms that you consider problematic:

O distractibility	O change in appetite	O suspicion / paranoia
O hyperactivity	O lack of motivation	O racing thoughts
O impulsivity	O withdrawal from people	O excessive energy
O boredom	O anxiety / worry	O wide mood swings
O poor memory / confusion	O panic attacks	O sleep problems
O seasonal mood changes	O fear away from home	O nightmares
O sadness / depression	O social discomfort	O eating problems
O loss of pleasure / interests	O obsessive thoughts	O gambling problems
O hopelessness	O compulsive behaviors	O computer addiction
O thoughts of death	O aggression / fights	O problems with pornography
O self-harm behaviors	O frequent arguments	O parenting problems
O crying spells	O irritability / anger	O sexual problems
O loneliness	O angry outbursts	O relationship problems
O low self worth	O flashbacks	O work / school problems
O guilt / shame	O hearing voices	O alcohol / drug use / abuse
O fatigue	O visual hallucinations	O other:________________________

How would you describe your overall mood/outlook?____

Briefly describe your major stressors (current and past). Please mention any ambitions, obstacles, difficulties, etc.

Have you been in counseling before? Yes No If yes, when and with whom?

What did you find helpful during your treatment?____

What was not helpful during your treatment?____

Are you currently prescribed and/or taking any psychotropic medications? Yes No

If yes, please list with physician who prescribes:____

Describe any trauma in your past:

Who is in your support network that you can discuss your problems or plans?

Describe any legal issues (arrests, misdemeanors, felonies, divorce, child custody, etc.)

Your Health

Height:______ Weight:_____ Date of last physical exam:_______________ Overall health: Excellent Good Fair Poor

What physician(s) follow(s) your health?____

Please describe any physical handicaps, chronic conditions, or health/medical worries:

What do you do to keep in good physical condition?____

What do you do to relax?____

How is your vision and hearing?____

When did you last visit a doctor?_____________ Why?____

Please list your current medications (including herbal and over-the-counter)

Have you ever been taken to the emergency room with a serious emergency, hospitalized, or had an outpatient surgery?

Yes No If yes, please describe condition/injury, treatment, any surgery, when, how long, and where.

Have you ever had a head injury and/or lost consciousness? Yes No If yes, how long? __________________

Occupation, Employment & Finances

Please list your current job, the types of jobs you have had and how long you held each job (e.g., Office Assistant 5 yrs., Insurance Agent 7 yrs, etc.):

Do you have a system of saving money? ______ Are you currently in financial crisis? Yes No

What financial help are you seeking in order to carry out your educational, vocational, or other plans?

If you do not pay your bills, who assists you? ____

List any military service in your background (branch, duties, date and type of discharge, combat time, etc.)

Hobbies, Interests and Traits

What are your present hobbies or interests?____

Past hobbies or interests (if different)?____

To what clubs, activities and organizations do you now belong?____

Is your social activity chiefly with groups of your own age or other ages?_________________________________

In sports, would you rather be a player or a spectator?____

What do you enjoy more than anything else?____

What habits or mind-sets do you have that might hinder you?____

What sort of person do you like best?____

What kind of person do you dislike?____

Do you have many acquaintances?__________ How many close friends?___________ Is that enough for you?_______

Do you have feelings of failure?_______ If so, about what?____

In the spaces below, list some of your prominent character traits:

Strengths

Weaknesses

Education

Highest level of education completed:___________________

List schools and colleges attended beginning with most recent:

Name	Dates	Grade completed or degree and degree program
__________________________	________________________	____
__________________________	________________________	____
__________________________	________________________	____
__________________________	________________________	____

How well did you like school?____

If starting over, would you choose the same area of study?____

Please describe any learning difficulties or disabilities you have had?____

If your education has been (or may be) cut off before completion, why?____

What further education do you plan?____

List subjects that you like very much:____

List subjects that you dislike:____

Has school been: Easy Fairly easy Difficult Very Difficult

What training or courses taken do you consider most valuable to you?____

If you had the time, what books would you like to read?

Of books you have read, did any make a great impression on you? Yes No

If so, which?

What else do you want me to know about you?