Personal History

Date:

Personal Information

Name: Date of birth:

Home address: City: State: Zip:

Email address:

Home phone: Work phone: Mobile phone:

OK to call: ❑ Home ❑ Work ❑ Mobile ❑ Restrictions on messages:

Emergency Contact

Name: Relationship:

Home phone: Work phone: Mobile phone:

Presenting Problems

Please tell me briefly what it is you want help with:

How might you be different as a result of therapy? Are there specific areas in your life that would be different? What would that look or feel like?

What might get in the way of therapy being successful for you?

Are there any cultural issues that would help me understand you better?

Psychiatric History

Are you working with a counselor, psychiatrist or treatment program now? ❑ Yes ❑ No

Name of Therapist/Psychiatrist: Phone:

Have you had counseling in the past? ❑ Yes ❑ No If so, how long?

Name of Therapist/Psychiatrist: Phone:

Address: City: State: Zip:

Have you ever been hospitalized for a psychiatric issue? ❑ Yes ❑ No If so, please tell me a little about this:

Name of hospital: Date:

Personal Safety

Are you currently having suicidal thoughts? ❑ Yes ❑ No

Have you ever attempted suicide in the past? ❑ Yes ❑ No If so, when?

Have you ever harmed yourself in any way, such as cutting or burning? ❑ Yes ❑ No If yes, please tell me about this:

Are you currently having thoughts of harming another person? ❑ Yes ❑ No

Have you ever physically harmed another person or damaged property or been arrested for a violent crime? ❑ Yes ❑ No If yes, please describe:

Medical History

Allergies:

Prescriptions Medications:

Non-prescription medications taken regularly:

How would you describe your health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please list any current medical problems:

Name of physician: Phone:

Address: City: State: Zip:

Education

Highest grade completed:

School performance? ❑ Great ❑ Average ❑ Mediocre ❑ Poor

Employment

Occupation:

❑ Full time ❑ Part time ❑ Unemployed ❑ On disability

Are you happy with your current career or work situation? Please explain:

Current Problems and Symptoms

Please rate your concerns using the following scale: **1.** No difficulty **2.** Mild difficulty **3.** Moderate difficulty **4.** Great difficulty **5.** Overwhelming difficulty

Job:	Financial:	Self control:
Family:	Illness:	Physical symptoms:
School:	Anxiety:	Emotions:
Alcohol or drug issues:	Sleep:	Thinking:
Partner or relationship:	Depression:	Other:
Coming out:	Appetite:	

Relationship Status

❑ Single ❑ Committed relationship ❑ Legally married ❑ Separated ❑ Partner/spouse deceased ❑ Divorced

Children? Names and ages:

Living arrangements? ❑ Alone ❑ With partner/spouse ❑ With roommate ❑ With children ❑ With relatives

Do you feel you have a supportive network of friends and family? ❑ Yes ❑ No

Current relationship issues?

Family History

Please tell me about the family you grew up in (i.e., did you feel supported, alone, scared?) How did your parents relate to each other, and to you?

How did people in your family express anger?

How did they express love and concern?

Describe the relationship you have with your family now:

Does anyone in the family have a history of psychiatric illness? ❑ Yes ❑ No ❑ Unsure

Does either parent abuse alcohol or drugs? ❑ Yes ❑ No ❑ Unsure

Are you a survivor of any type of childhood abuse? ❑ Yes ❑ No ❑ Unsure

If yes, what type of abuse? ❑ Neglect ❑ Emotional ❑ Physical ❑ Sexual

Are there any recent or current childhood, adolescent or adult abuse towards you that you want to inform me of or talk about?

Other

Do you or someone close to you feel that you have a problem with over-eating, eating too little, or vomiting after over-eating?

Do you or someone close to you feel that you have a problem with other behaviors such as gambling or sexual compulsions that you want to discuss?