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PERSONAL HISTORY QUESTIONNAIRE

Please complete this form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form. If you do not desire to answer any question, merely write "Do not care to answer." If certain questions do not apply to you, leave them blank. Please print or write as legibly as possible.

Date _____

General Information

Name (including any nicknames) _____

Address _____

City _____ State _____ Zip code _____

Telephone Numbers Home: _____ Work:_____ Cell phone _____

For routine messages: Phone # _____ Email:_____

Person & Phone # to call in case of emergency:_____

Occupation _____Education (Highest degree earned) _____

Date of Birth _____ Age _____

With whom are you now living? (list names and relationship) _____

_____

Past & Present Marriage/Relationship(s): (names, years together, and statement about the nature of the relationship (s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile)

_____

_____

Present Spouse/Partner Education & Occupation _____

Children/Step/Grandchildren (names/ages & brief statement about your relationship with the person)

1._____

2._____

3._____

Parents/stepparents (Name/age or year of death/cause of death, occupation, personality, how does/did s/he treat you, brief statement about the relationship):

Father:_____

_____

Mother: _____

_____

Stepparents: _____

_____

Siblings (name/age, if deceased: age and cause of death and brief statement about the relationship:

1. _____
2. _____
3. _____
4. _____

Family History

Describe your childhood in general (relationships with parents, siblings, others, school/behavioral problems, abusive/alcoholic parent, relocations)

_____

_____

_____

_____

What were some of your nicknames from childhood? _____

If Parents Divorced: Your age at the time _____ Describe how it affected you at the time

_____

Family History of alcoholism, drug abuse, mental illness, or violence (including suicide, depression, hospitalizations in psychiatric institutions)

_____

_____

Family Medical History (Describe any illness that runs in the family – cancer, epilepsy, etc.)

_____

_____

Medical Information & History

Medical Doctor (s) (name/phone) _____

Date of last physical exam _____

Are you currently under the care of a psychiatrist or other mental health practitioner? _____

If yes, please list name _____

List any physical concerns at present (high blood pressure, headaches, dizziness, etc.)

_____

_____

List any major illnesses and/or operations experienced in the past (including traumatic injury, head trauma, etc)

_____

_____

How many pregnancies have you experienced if any? _____

Specify Medication (s) you are currently taking and for what purpose. **Print clearly:**

_____

_____

List any medications you have taken in the last 5 years: _____

On average, how many hours do you sleep daily? _____

Do you have trouble falling asleep or staying asleep? _____

Describe your appetite _____ Poor _____ Average _____ Large

Have you experienced any recent significant weight loss or gain? _____ Loss _____ Gain

How many times per week do you exercise? _____ Approximately how long each time? _____

What is your daily intake of the following?

Number of cups/glasses of: ___ regular coffee ___ regular tea ___ other caffeinated drinks

Number of cans or glasses of: ___ beer ___ wine ___ mixed drinks ____ water

Past/Present drug/alcohol use/ abuse (Marijuana, nicotine, other)

_____

_____

Suicide attempt/s or violent behavior (describe ages, reasons, circumstances and other pertinent details)

_____

_____

Have you experienced abuse in the past (physical, verbal, emotional, sexual)**?** If yes, please explain:

_____

_____

_____

Clinical Information

1. State in your own words the nature of your chief concerns (be as specific as you can: when did it start, how does it affect you.):

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____

2. PAST/PRESENT PSYCHOTHERAPY (specify: year(s); Name of counselor, degree, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how/why it ended):

_____

_____

_____

3. How do you want things to be different as a result of counseling?

_____

_____

_____

4. List your 3 greatest strengths:

1._____

2._____

3. _____

5. Underline any and all of the following that apply to you:

Feel stupid
Repetitive behaviors
Bowel disturbances
Shame
Feel tense
Depressed
Recent Wt. Loss/Gain
Can't make friends
Good sense of humor
Home conditions bad
Legal problems
Don't care anymore
Strange thoughts
Feeling guilty
Impulsive
Aggressive
Helplessness
Decreased sex drive
Fear being alone
Explosive
Attractive
Pornography use
Extra Energy
Thoughts racing
Can't catch my breath
Fears
Feel apart from people
Over eat
Take too many risks
Headaches
Crazy
Worthwhile
Loyal
Honest
Morally degenerate/Evil

Dizziness
Stomach troubles
Fatigue/Tired
Vomiting
Feel panicky
Suicidal thoughts
Sexual problems
Can't make decisions
Inferiority feelings
Increased sex drive
Caring person
Education problems
Poor memory/forgetful
Anxious
Distant from God
Perfectionist
Unappreciated
Numb
Unwanted reoccurring thoughts or behaviors
Distractible/Difficulty completing tasks
Confident
Physical pain
Nightmares
Lose my temper too quickly
Suspicious
Awaken too early
Nothing is fun anymore
Dishonest
Sensitive
Can't keep a job
Don't feel alive inside
Unlovable
Full of regrets
Want to change myself

Fainting spells
Unable to relax
Difficulty Sleeping
Death of family/friend
Unattractive
Excessive spending
Hopeful
Feel lonely
Financial problems
Self-control
Stress
Difficulty Concentrating
Changes in appetite
Nauseous
Can't feel anything
Misunderstood
Heart pounding
Withdrawn
Stubborn
Overly criticized
Restless
Hard working
Grief
Repetitive thoughts
Strange experiences
Work problems
Jump at loud sounds
Crying
Intelligent
Drug use/Alcohol problems
Naïve/Trusting
Ambitious
Angry/Resentful
Trustworthy
Chronic illness or pain

6. Circle the five most troublesome symptoms underlined above in question #5.

7. List your three main worries or fears:

1.

2.

3.

8. What gives you the most pleasure in your life? What are some positive feelings you've experienced recently?

_____

_____

_____

9. What are your most important hopes or dreams?

_____

_____

_____

10. Describe your friendships, community of support and spirituality

11. Do you or have you struggled with any compulsive behaviors? (i.e., gambling, internet, pornography, compulsive eating, exercise, prostitutes, stealing, high-risk activities, massage parlors, shopping) Other:

12. ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL ÓR CRIMINAL LITIGATION(S), LAWSUIT(S) OR DIVORCE OR CUSTODY DISPUTE(S)? (if you answer Yes, please explain):

Religious/Spiritual Information

1. Are religious or spiritual issues important in your life? _____ Yes _____ No _____ Somewhat

2. How would you describe your faith or religion or guiding philosophy?

3. Do you wish to discuss these in counseling when relevant?

4. If yes, how would you like God to be a part of your therapy if at all?

5. Is there any other information you would like me to know about your situation?