ADULT PERSONAL HISTORY

This questionnaire helps your therapist obtain routine background information which may relate to your present concern. By answering the questions fully and accurately your counseling time can be used more effectively. We understand that you may be concerned about what happens to this information. Be assured that no one will reveal information about you to anyone without your written permission, except where life or safety are seriously threatened or where required by law. If you do not know the answer to a question or wish not to answer, draw a line through the question. Please check all items that apply.

Please describe in your own words what problem or situation brings you to treatment at this point in time:

_____
_____
_____

What improvement(s) do you want from treatment?

_____
_____
_____

Family History

1. List members of your household besides yourself.

Name	**Age**	**Relationship**	**Legal Custody**
_____	_____	_____	[ ] Yes [ ] No
_____	_____	_____	[ ] Yes [ ] No
_____	_____	_____	[ ] Yes [ ] No
_____	_____	_____	[ ] Yes [ ] No

2. What is your current marital status? [ ] Never married [ ]Married [ ]separated [ ]divorced [ ]widowed

3. How long have you been with your current partner? _____

4. How many marriages have you had? _____ Check if none [ ]

5. How many children have you had? _____ Check if none [ ]

6. Describe your satisfaction with your current relationship:
[ ] Extremely satisfied [ ] Fairly satisfied [ ] Fairly dissatisfied [ ] Not satisfied

7. With whom did you live while growing up? _____

8. Number of brothers and sisters (include step, half, foster, adopted). _____

9. Describe any events during your childhood that had a profound effect on your life.
(e.g. loss of parent, a significant achievement, alcohol/drug abuse).
_____

School/Work

10. Education (Indicate highest level completed)
[ ] Grade school or less [ ] Some high school [ ] High school or equivalent
[ ] Vocational/technical [ ] Some college [ ] College degree
[ ] Graduate studies [ ] Graduate degree

11. Are you currently experiencing any problems or stress at work? [ ] Yes [ ] No
If yes, please explain _____

12. Are you currently experiencing financial difficulties? [ ] Yes [ ] No If yes, please explain: _____
_____

13. Current employment status: [ ] Full time [] Part time [ ] Retired
[ ] Unemployed, looking for work [ ] Unemployed, not looking for work

14. Any military experience? [ ] Yes [ ] No (Indicate status) [ ] Active [ ] Reserve [ ] Veteran
Type of Discharge [ ] Honorable [ ] Dishonorable [ ] Medical [ ] Other

Social History

15. Are you involved in any community/religious activities? [ ] Yes [ ] No If yes, please explain:
_____

16. Do you participate in any hobbies or leisure activities? [ ] Yes [ ] No If yes, please explain: _____
_____

17. Do you have close friends or family with whom you can discuss problems? [ ] Yes [ ] No
If yes, please explain: _____

Substance Use

18. Do you presently use any drugs or alcohol? [ ] Yes [ ] No If yes, please indicate which drugs you use, the amount of use and the frequency of use: (e.g. alcohol, two glasses of beer every day) (Also, please indicate if you smoke cigarettes/cigars OR take sleeping pills)
_____
_____
_____

19. Have you ever been treated for drug/alcohol problems? [ ] Yes [ ] No
If yes, please explain: _____
How long did you stay clean after leaving the program?_____

20. Please specify which family members, if any, were/are affected by drug/alcohol dependence.
Check if none [ ]. _____

(Please continue on page 3)

Previous Psychological/Psychiatric Treatment

21. Have you ever seen a psychologist, psychiatrist or other mental health professional on a regular basis?
[ ] Yes [ ] No If yes, please give the name(s) of therapist(s) and dates seen:
Name (s) of Therapist _____ Dates: _____
_____ Dates:_____
_____ Dates: _____
_____ Dates: _____
Reason(s) for seeking help: _____
_____
_____
_____

22. Have you ever received treatment at an inpatient psychiatric hospital? [ ] Yes [ ] No
Facility Name: _____ Date: _____ Length of Stay: _____
Reason for hospitalization: _____

Facility Name: _____ Date: _____ Length of Stay: _____
Reason for hospitalization: _____

23. Do you have any current medical condition? [ ] Yes [ ] No If yes, please state the condition(s) for which you are being treated: _____

24. Please list all medications which you currently take. _____
_____
_____

Known Allergies

25. Have you ever experienced any adverse/bad reaction to any kind of medicine, food, plant or substance?
[ ] Yes [ ] No If yes, please indicate the source of your allergy (allergies) and describe your reaction(s):_____
_____

26. During the past 60 days (2 months) have you experienced any of the following problems on a persistent basis for two weeks or longer?
[ ] Severe Depression [ ] Difficulty staying awake [ ] Difficulty falling asleep
[ ] Unable to get out of bed in the morning [ ] Repeated feelings of hopelessness
[ ] Loss of interest in sex [ ] Repeated thoughts about harming/ killing yourself
[ ] Repeated thoughts about harming/killing someone else [ ] Dramatic reduction in food intake
[ ] Dramatic increase in food intake [ ] Other _____

_____ _____
Signature of Patient Signature of Person Completing Form
(if different from patient/client)

PAGE 4 ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO PROVIDE: