Personal History Form

Date_______________

Full Name ________________________________ DOB _______________ Age ___________

Psychological History
What issues bring you to counseling/therapy today?____

____
How will you know when your therapy is complete?____

____
Have you been in counseling before? Y N When? _____________ With Whom? ________________
What was helpful about it? ____

____
Have you ever thought about hurting yourself? _____ How recently? ____________
Have you ever tried to hurt yourself? _____ How recently? ____________
Have you ever thought about hurting someone else? _____ How recently? ____________
Have you ever tried to hurt someone else? _____ How recently? ____________

Rate your level of distress over the last six weeks for each symptom using the scale below
1 2 3 4 5
None Mild Moderate Considerable Severe
____ Depression ____ Anxiety ____ Hopelessness ____ Mood swings ____ Anger/rage
____ Guilt ____ Grief/loss ____ Perfectionism ____ Obsessions ____ Withdrawal
____ Fearfulness ____ Memory ____ Concentration ____ Hallucinations ____ Self-esteem

Medical History
Primary Care Physician's Name ________________________________ Phone _____________
Date of Last checkup ____________ Significant Findings ______________________________
Other
Physicians____

Please list any medications you are currently taking
Medication Dosage Reason Date Started

____
____
____
Any drug sensitivities or allergies:

____
Amount of **caffeinated** beverages consumed per day: coffee _______ soda _______ espresso _______ tea _______
Number of cigarettes smoked per day: ________
How often do you use alcohol or other drugs per week? _________________
Do you use alcohol or drugs to (check all that apply): manage stress?______ relax?______ change mood?______ sleep?______
Think of the occasion that you drank the most in the **past month**. How much did you drink?_____ How many hours did you drink?______

Please check any current or past medical conditions
_____ Diabetes _____ Lung Disease _____ STDs _____ Rheumatic Fever _____ Cancer _____ Arthritis _____ Ulcer
_____ Heart Disease _____ Jaundice _____ Kidney Disorder _____ Thyroid Disease _____ Hepatitis _____ Anemia _____ TB _____ Head Injuries _____ Cirrhosis _____ Bone Disorder _____ Nerve Disorder _____ Seizures _____ Pneumonia _____ Colitis _____ Auditory _____ TMJ _____ Muscular Disorder _____ Low/High Blood Pressure _____ Sensory Integration
_____ Other: ____

Rate your level of distress over the last six weeks for each symptom using the scale below
1 2 3 4 5
None Mild Moderate Considerable Severe
____ Sleep Patterns ____ Eating Patterns ____ Health Concerns ____ Panic Attacks
____ Weight Loss ____ Weight Gain ____ Sexual Problems ____ Alcohol/Drug Abuse/Addiction

Family/Relationship/Social History
I am: ___Single ___Living w/Significant other ___Married ___Partnered ___Separated ___Divorced ___Widowed
___Remarried ____ Number of Marriages

People Living in your Home

Name **Age** **Relationship to you**

____
____
____
____
____

Family of Origin Information

First Parent's Name ____________________________ Current Age _____ Living?____ If deceased, when? ________

Second Parent's Name __________________________ Current Age _____ Living?____ If deceased, when? ________

Step-parent's Name ____________________________ Current Age _____ Living?____ If deceased, when? ________

Step-parent's Name ____________________________ Current Age _____ Living?____ If deceased, when? ________

I am the _______ of _______ children in my family. (ie - I am the first of 3 siblings in my family.)
I have _______ brothers and _______ sisters.
What mental health issues has your biological family faced (Please describe)?
____
____

Is there a history of substance abuse in your family?____ Please describe
____
____

Please describe any support systems or community resources you are a part of
____
____

Education (list highest level completed) ____________________ Other training completed ____________________
Military service? _____ Branch ____ Served in combat? _____
Current employment ___________________________________ How long? _________ Are you satisfied? _______

Rate your level of distress over the last six weeks for each symptom using the scale below

1 2 3 4 5
None Mild Moderate Considerable Severe

____ Parenting Issues ____ Domestic Violence ____ Communication ____ Partner Conflicts
____ Parental Conflicts ____ Financial Problems ____ Pornography ____ School/work Conflicts
____ Legal Problems ____ Gambling Problems ____ Sibling Conflicts ____ Job/employment Problems
____ Computer Problems/Addiction

Spiritual/Other Resources

Centus is a counseling center that is open to the incorporation of one's spirituality as a resource for change in therapy.
Describe activities you participate in which you would consider life-giving
____
____

How would you describe your current spiritual life and/or practices?
____
____
____

Please list any alternative resources you currently utilize to maintain your physical, mental and/or spiritual health (ie - meditation, yoga, acupuncture, prayer, volunteering, etc.).
____
____

____ Client Signature