PERSONAL HISTORY FORM

□ MENTAL HEALTH □ SUBSTANCE ABUSE □ BOTH CLIENT ID # _____

FORM COMPLETED BY (If someone other than client)_____

A) What brought you into treatment: _____

_____

B) What are your expectations for treatment_____

_____

C) Prior treatment experiences (Dates and Location_____

_____

D) Name of Primary Care Physician_____Phone_____

E) **Current Living Arrangements*:***

1. □ House □ Group Living □ Apartment □ Other (Specify)_____
2. □ Alone □ With Family □ Unrelated Significant Other

I. **CLIENT INFORMATION (past and present)**

1) **Treatment Experiences**

	Yes	No	Inpat./Outpt/ IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous)					

2) **Presenting Problem** (Check all boxes that apply)

□ Medical/Organic condition
□ Depression
□ Mania
□ Chemical Abuse/Dependency
□ Delusions/Hallucinations
□ Family Issues
□ Relationship Issues
□ Other (please elaborate)
□ Anxiety
□ Aggressive Behavior
□ Suicidal Ideation's
□ Self-destructive Behavior
□ Anger
□ Life Decision
□ Uncertain

3) **Symptoms**

Any recent changes in:

	Yes	No		Yes	No
Sleeping patterns	□	□	Physical Activity Level	□	□
Eating Patterns	□	□	General Disposition	□	□
Behavior	□	□	Weight	□	□
Energy	□	□	Increased tension	□	□

If yes to any of the above, please describe

Are you in physical pain □ yes □ no if yes where/what kind

_____

If yes please rate pain_____ 0=none 5=mild(tolerable) 10=severe(referral)

THERAPY IMPLICATIONS: _____

_____

II. **INFORMATION ABOUT FAMILY / SIGNIFICANT OTHERS;** past and present

1. **Family Constellation**

	NAME	CURRENT AGE	CURRENTLY LIVING		CURRENTLY LIVING WITH YOU	
Client			YES	NO	YES	NO
Mother						
Father						
Spouse						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents Step-relatives, Half-relatives) *Specify Relationship*						

2) **FAMILY/EXTENDED FAMILY HISTORY**

	Yes	No	Inpt/Outpt/IOP	When	Where
Counseling/Psychiatric treatment					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Involvement with self-help groups					

3) **Family History**

1. What City/State were you born? _____
2. Where did you grow-up? _____
3. Who raised you as a child? _____

4) **Parental Information**

- ☐ Parents legally married
- ☐ Parents ever separated
- ☐ Parents ever divorced
- ☐ Mother remarried (number of times)
- ☐ Father remarried (number of times)_____

Describe relationships with parents, step-parents

1. As a child_____

_____

2. Currently_____

_____

5) SIBLING INFORMATION

Number of living siblings/step siblings_____ Number of deceased siblings/step-siblings

What position are you in the order of siblings (oldest, 2nd, 3rd, youngest, etc.) _____

Describe relationships with siblings:

1. As a child_____

2. Currently_____

- ☐ Family will be involved in treatment
- ☐ Family uninvolved

Why/Why Not:_____

_____

6) **Marital Information**

□ Single □ Unmarried and living with significant other. Length of time_____

□ Legally married: Length of time:_____ Total number of marriages:
□ Separated: Length of time_____ □ Divorce in process: Yes □ No □

□ Divorced: Length of time_____ □ Widowed: Length of time

Are there problems in this relationship (check all that apply)

□ Money □ Chemical Dependency

□ Sexual □ Mental illness

□ Physical Abuse □ Religion

□ Child rearing/discipline issues □ Other

THERAPY IMPLICATIONS:_____

III. **SOCIAL INFORMATION**

1) **Support System** (check all that apply)

□ Adequate social support □ Recent move / relocation □ Conflict with peers

□ Transportation problems □ Lack of knowledge of resources □ Isolative

□ Problems establishing / maintaining relationships

Please list involvement in community resources (e.g. WIC, CMH, Day treatment, groups) _____

THERAPY IMPLICATIONS:_____

2) **Sexuality**

What is your sexual preference □ Male □ Female □ Both □ Uncertain

Have you been tested for HIV □ Yes □ No

Are there sexual issues that you would like to discuss with your therapist? □ Yes □ No

Have you ever been sexually and/or physically abused? □ Yes □ No

THERPAY IMPLICATIONS:_____

3) **Interests/Hobbies**

Art_____ Book/Films_____
Music_____ Physical Fitness
Crafts_____ Outdoor Activity
Sports_____ Diet/Health

Current Memberships (church , clubs, organizations)
Do you participate in any cultural activities related to your ethnic background? □ Yes □ No

THERAPY IMPLICATIONS:_____

4) **Spirituality**

Do you believe in a god or a power greater than yourself? □ Yes □ No

What religion were you raised? _____

What religion are you currently affiliated?_____

At this point in your life, what is most important to you? _____

THERAPY IMPLICATIONS:_____

IV. **EDUCATION** (check all that apply)

□ High school diploma (GED) □ Currently enrolled: Last grade completed _____

□ Did not complete high school: last grade completed _____
□ □ Vocational training: □ Training completed, type_____ □ Currently enrolled
□ College: Degree earned, type_____ □ Currently enrolled/# of years completed_____
□ Special circumstances (e.g. learning disabilities, gifted programs, special education, etc.)

THERAPY IMPLICATIONS: _____

V. **EMPLOYMENT/VOCATIONAL** (Beginning with most recent job, give employment history, include homemaker experience)

Employer	Dates	Job Description	Salary

THERAPY IMPLICATIONS: _____

VI. **MILITARY**

Branch_____ Type of Discharge
Date drafted/enlisted_____ Rank at Discharge
Combat experience □ Yes □ No Date of Discharge_____Where

Where _____

THERAPY IMPLICATIONS: _____

VII. **LEGAL DATA**

Are you presently on probation or parole: □ Yes □ No

If yes reason _____ From _____ To _____

Current Status:

Are you currently involved in any active legal cases (traffic, civil, criminal): □ Yes □ No

If yes, please describe and indicate the court hearing/trail date_____

_____

Past History (adolescent and adult)

Yes	No	
□	□	Traffic Violations
□	□	Civil Involvement
□	□	Criminal Involvement

If yes to any of the above, please complete the following

Charges	Date	Where	Results

THERAPY IMPLICATIONS:_____

VIII Nutritional Assessment

Please circle the answer or indicated number and total the score from both columns at the bottom.

QUESTION		
Do you have an illness/condition that made you change the type/amount of food you eat?	Yes=2	No
Do you eat at least two or more meals per day?	Yes	No=3
Do you eat fruits or vegetables, or milk products every day?	Yes	No=2
Do you have 3 or more drinks of beer, liquor, or wine almost every day?	Yes=2	No
Do you have teeth or mouth problems that make it hard for you to eat?	Yes=2	No
Do you always have enough money to buy the food you need?	Yes	No=4
Do you eat alone most of the time?	Yes=1	No
Do you take 3 or more prescription or over-the-counter drugs?	Yes=1	No
Have you lost or gained 10 lbs. in the last six months?	Yes=1	No
Are you always physically able to shop, cook, and/or feed yourself?	Yes	No=2

TOTAL SCORE _____

0-2= Low Risk 3-5= Moderate Risk 6-21= High Risk* *Referral

THERAPY IMPLICATIONS:

_____

IX TRAUMA

Any history of trauma, abuse, neglect or exploitation? □ No □ Yes

If yes: When and type _____

_____

THERAPY IMPLICATIONS: _____

X Alcohol/Substance Use

Substance preferred _____

Date of last drink _____ / Date of last drug use _____

Type and amount of drink at last episode □ Beer _____oz □ Wine _____ oz □ Liquor ____ oz

Age drinking/ drug use began _____

Type of alcohol preferred: □ Beer □ Wine □ Liquor

How often do you drink/use drugs? □ Daily □ Weekly □ Monthly □ Other _____

Have you ever had any legal problems related to your use of alcohol/drugs? □ Yes □ No

Have you ever had any relationship problems related to your use of alcohol/drugs? □ Yes □ No

*****Has drinking or drug use ever become a problem? □ Yes □ No**

*****If YES, please complete next page. (Substance Abuse Addendum)**

If NO go to page 10

THERAPY IMPLICATIONS: _____

SUBSTANCE USE ADDENDUM

I. USAGE HISTORY

Drug type	Method of use	Age first used	Age of regular, daily use	Date last used	Last 48 hours	Last 30 days	Last year
A. DEPRESSANTS							
Alcohol (beer, wine, liquor)							
Anti-Anxiety Agents (Valium, Librium, Tranxene, Xanax, Ativan, Serax, etc.)							
Barbiturates (Phenobarbital, Tuinal, Seconal, etc.)							
Others (Methaqualone, Paraldehyde, Equanil, Miltown, muscle relaxants, etc.)							
B. NARCOTICS (Heroin, Opium, Morphine, Codeine (Tylenol #3/#4, Cough Syrup), Methadone, Dilaudid, Percodan, Darvon, Talwin, etc.)							
C. STIMULANTS							
Amphetamines (Benzedrine, Dexedrine, Ritalin, etc.)							
Cocaine/Crack							
Caffeine							
Nicotine							
D. CANNABIS (Marijuana, Hashish)							
E. INHALANTS (glue, poppers, gasoline, etc.)							
F. HALLUCINOGENS							

THERAPY IMPLICATIONS:

ALCOHOL/DRUG RELATED PROBLEMS/BEHAVIORS/SYMPTOMS LIST

Please check all that apply.

PHYSICAL	EMOTIONAL	BEHAVIORAL
_____ Blackouts	_____ Depression	___ A.M. Use
_____ Memory Problems	_____ Confusion	___ Sneaking
_____ Tremors/ Shakes	_____ Concentration Problems	___ Gulping
_____ Seizures	_____ Anxiety	___ Loss of Control
_____ DT=s	_____ Irritability / Restlessness	___ Relief Use
_____ Hallucinations	_____ Aggressiveness	____ Impulsive Use
_____ Overdose	_____ Mood Swings	____ Use less than before
_____ Appetite Problems	_____ Impulsivity	___ Use more than before
_____ Nausea/ Vomiting	_____ Euphoria	____ Use despite negative Consequences
_____ Sleep Problems	_____ Relaxation	___ Associate with using friends
_____ Sexual Problems	_____ Extreme Jealousy	___ Plan activities around use
_____ Injury	_____ Paranoia	___ Loss of interest in activities
_____ Accidents	_____ Feelings of Guilt/ Shame	___ Change in work/school performance
_____ Other Medical Problems	_____ Suicidal Thoughts	___ Work/school lateness/ absenteeism
_____ Other	_____ Homicidal Thoughts	___ Job loss due to use
	_____ Other	___ Frequent arguments
		___ Separation/divorce
		___ Financial problems
		___ Legal problems
		___ Physically abusive to self
		___ Physically abusive to others
		___ Suicide attempts
		___ Homicide attempts
		___ Other

If any of the above are checked off, please describe:_____
_____
_____
_____

III. SUBSTANCE ABUSE FAMILY HISTORY

Please describe the alcohol/drug problems of others in your family, past and present. Also describe treatment and recovery experience.

WHO/RELATIONSHIP	PROBLEM TYPE	TREATMENT/RECOVERY

XI. **MEDICAL INFORMATION** (past and present)

1. **Recent Treatment History**

	Date	Reason	Results
Last physical check-up			
Last Doctor's visit			
Last Dental visit			

2. **Review of Past/Present Conditions**

Please check any of the following medical problems you have, or have had in the past:

- ☐ Adrenal problems
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Seizures/Epilepsy
- ☐ Meningitis or Encephalitis
- ☐ Head Injury/Loss of Consciousness
- ☐ Kidney/Bladder problems
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Sexually transmitted disease
- ☐ Anemia
- ☐ Liver problems
- ☐ Lung problems
- ☐ Heart problems
- ☐ Allergies
- ☐ Brain Tumor
- ☐ Cancer
- ☐ Glaucoma
- ☐ Asthma

If yes to any of the above, please describe and give dates:_____

_____

3) **Current Medical Symptoms/Problems:**

Please check all that pertain to you now:

EYES
- ☐ Double Vision
- ☐ Eye pain
- ☐ Problems with vision

EARS
- ☐ Hearing Aid
- ☐ Buzzing/Ringing in ears
- ☐ Infection in ears
- ❒ Problems with balancing
- ☐ Problems with hearing

NOSE
- ☐ Nose bleeds
- ☐ Stuffy nose

MOUTH
- ☐ Loss of taste
- ☐ Problems with teeth
- ☐ Dentures

RESPIRATORY
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Sputum/mucus production
- ☐ Positive TB test
- ☐ Coughing up blood

SKIN/JOINT/MUSCLE
- ☐ Changes in skin
- ☐ Changes in nails
- ☐ Changes in hair
- ☐ Skin rash
- ☐ Skin itchy/dry
- ☐ Cramps in legs/arms
- ☐ Stiff/swollen joints
- ☐ Difficulty walking

GASTROINTESTINAL
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Abdominal pain

GENITO/URINARY
- ☐ Pain/burning with urination
- ☐ Frequent urination at night
- ☐ Bloody/brown urine
- ☐ Difficulty starting urine flow
- ☐ Constant need to urinate

.**NERVOUS SYSTEM**
- ☐ Headaches
- ☐ Numbness
- ☐ Fainting spells
- ☐ Convulsions/seizures
- ☐ Memory problems
- ☐ Coordination problems
- ☐ Tremor/shakes
- ☐ Loss of movement
- ☐ Loss of sensation

GENERAL HEALTH
- ☐ Overweight
- ☐ Underweight
- ☐ Chills
- ☐ Fever
- ☐ Tire easily
- ☐ Night/day sweats

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart skips a beat
- ☐ Palpitations
- ☐ Fast heart rate
- ☐ Chest pains
- ☐ Swollen ankles

FEMALES ONLY
- ☐ Menstrual irregularities
- ☐ Menopause
- ☐ Problem pregnancy
- ☐ Miscarriage #_____
- ☐ Abortion # _____
- ☐ Premenstrual problems
- ☐ Infertility
- ☐ Currently pregnant

If you checked any of the above, please describe:_____

4) **Medication and Drug Use**

Include prescription, non-prescription, and illegal drugs

Name of Drug	Prescribed	Prescribing Physician	Date 1st used	Date last used	Amount last used	Used in past 48 hr
	yes no					
	yes no					
	yes no					
	yes no					

Any history of drug overdose: □ Yes □ No If yes, please describe:

Any medication allergies? □ Yes □ No If yes, please describe:_____

_____

Do you believe you would benefit from any of the following?

□ Anger Management Education Series □ Substance Abuse Education Series □ Grief Group

- -

STAFF USE ONLY

Client currently being treated by Primary Care Physician for symptoms checked on page 10
□ yes □ no □ n/a

Referred for physical □ yes □ no

_____ _____

CLINICIAN SIGNATURE/CREDENTIALS **DATE**

_____ _____

PSYCHOLOGIST SIGNATURE **DATE**

Physician □ agrees □ disagrees with referral

If disagree reason _____

_____

_____ _____

PHYSICIAN SIGNATURE **DATE**