

PERSONAL HISTORY FORM

- MENTAL HEALTH SUBSTANCE ABUSE

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

	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)

- | | |
|--|--|
| <input type="checkbox"/> Medical/Organic condition | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Aggressive Behavior |
| <input type="checkbox"/> Mania | <input type="checkbox"/> Suicidal Ideation's |
| <input type="checkbox"/> Chemical Abuse/Dependency | <input type="checkbox"/> Self-destructive Behavior |
| <input type="checkbox"/> Delusions/Hallucinations | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Family Issues | <input type="checkbox"/> Life Decision |
| <input type="checkbox"/> Relationship Issues | <input type="checkbox"/> Uncertain |
| <input type="checkbox"/> Other (please elaborate) | |

3) **Symptoms**

Any recent changes in:

	Yes	No		Yes	No
Sleeping patterns	<input type="checkbox"/>	<input type="checkbox"/>	Physical Activity Level	<input type="checkbox"/>	<input type="checkbox"/>
Eating Patterns	<input type="checkbox"/>	<input type="checkbox"/>	General Disposition	<input type="checkbox"/>	<input type="checkbox"/>
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Weight	<input type="checkbox"/>	<input type="checkbox"/>
Energy	<input type="checkbox"/>	<input type="checkbox"/>	Increased tension	<input type="checkbox"/>	<input type="checkbox"/>

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	
			YES	NO	YES	NO
Client						
Mother						
Father						
Spouse						
Significant Other						
Children						
Significant Others: (Brothers, Sisters, Grandparents Step-relatives, Half-relatives) <i>Specify Relationship</i>						

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

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 _____
Date drafted/enlisted _____
Combat experience Yes No
Where _____

Type of Discharge _____
Rank at Discharge _____
Date of Discharge _____ 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/trial date _____

Past History (adolescent and adult)

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Traffic Violations
<input type="checkbox"/>	<input type="checkbox"/>	Civil Involvement
<input type="checkbox"/>	<input type="checkbox"/>	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	Yes	No
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 (Benedrine, 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
<input type="checkbox"/> Blackouts <input type="checkbox"/> Memory Problems <input type="checkbox"/> Tremors/ Shakes <input type="checkbox"/> Seizures <input type="checkbox"/> DT=s <input type="checkbox"/> Hallucinations <input type="checkbox"/> Overdose <input type="checkbox"/> Appetite Problems <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Sexual Problems <input type="checkbox"/> Injury <input type="checkbox"/> Accidents <input type="checkbox"/> Other Medical Problems <input type="checkbox"/> Other	<input type="checkbox"/> Depression <input type="checkbox"/> Confusion <input type="checkbox"/> Concentration Problems <input type="checkbox"/> Anxiety <input type="checkbox"/> Irritability / Restlessness <input type="checkbox"/> Aggressiveness <input type="checkbox"/> Mood Swings <input type="checkbox"/> Impulsivity <input type="checkbox"/> Euphoria <input type="checkbox"/> Relaxation <input type="checkbox"/> Extreme Jealousy <input type="checkbox"/> Paranoia <input type="checkbox"/> Feelings of Guilt/ Shame <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Homicidal Thoughts <input type="checkbox"/> Other	<input type="checkbox"/> A.M. Use <input type="checkbox"/> Sneaking <input type="checkbox"/> Gulping <input type="checkbox"/> Loss of Control <input type="checkbox"/> Relief Use <input type="checkbox"/> Impulsive Use <input type="checkbox"/> Use less than before <input type="checkbox"/> Use more than before <input type="checkbox"/> Use despite negative Consequences <input type="checkbox"/> Associate with using friends <input type="checkbox"/> Plan activities around use <input type="checkbox"/> Loss of interest in activities <input type="checkbox"/> Change in work/school performance <input type="checkbox"/> Work/school lateness/ absenteeism <input type="checkbox"/> Job loss due to use <input type="checkbox"/> Frequent arguments <input type="checkbox"/> Separation/divorce <input type="checkbox"/> Financial problems <input type="checkbox"/> Legal problems <input type="checkbox"/> Physically abusive to self <input type="checkbox"/> Physically abusive to others <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Homicide attempts <input type="checkbox"/> 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:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Adrenal problems | <input type="checkbox"/> Head Injury/Loss of Consciousness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Brain Tumor |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Meningitis or Encephalitis | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Allergies | |

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:

- | | | |
|--|---|---|
| <p><u>EYES</u></p> <p><input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> Problems with vision</p> <p><u>EARS</u></p> <p><input type="checkbox"/> Hearing Aid</p> <p><input type="checkbox"/> Buzzing/Ringing in ears</p> <p><input type="checkbox"/> Infection in ears</p> <p><input checked="" type="checkbox"/> Problems with balancing</p> <p><input type="checkbox"/> Problems with hearing</p> <p><u>NOSE</u></p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Stuffy nose</p> <p><u>MOUTH</u></p> <p><input type="checkbox"/> Loss of taste</p> <p><input type="checkbox"/> Problems with teeth</p> <p><input type="checkbox"/> Dentures</p> <p>irregularities</p> <p>Menopause</p> <p><u>RESPIRATORY</u></p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> Sputum/mucus production</p> <p><input type="checkbox"/> Positive TB test</p> <p><input type="checkbox"/> Coughing up blood</p> <p><u>SKIN/JOINT/MUSCLE</u></p> <p><input type="checkbox"/> Changes in skin</p> <p><input type="checkbox"/> Changes in nails</p> <p><input type="checkbox"/> Changes in hair</p> <p><input type="checkbox"/> Skin rash</p> <p><input type="checkbox"/> Skin itchy/dry</p> | <p><u>GASTROINTESTINAL</u></p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Heartburn</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Blood in stool</p> <p><input type="checkbox"/> Black tarry stool</p> <p><input type="checkbox"/> Abdominal pain</p> <p><u>GENITO/URINARY</u></p> <p><input type="checkbox"/> Pain/burning with urination</p> <p><input type="checkbox"/> Frequent urination at night</p> <p><input type="checkbox"/> Bloody/brown urine</p> <p><input type="checkbox"/> Difficulty starting urine flow</p> <p><input type="checkbox"/> Constant need to urinate</p> <p><u>NERVOUS SYSTEM</u></p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Fainting spells</p> <p><input type="checkbox"/> Convulsions/seizures</p> <p><input type="checkbox"/> Memory problems</p> <p><input type="checkbox"/> Coordination problems</p> <p><input type="checkbox"/> Tremor/shakes</p> <p><input type="checkbox"/> Loss of movement</p> <p><input type="checkbox"/> Loss of sensation</p> | <p><u>GENERAL HEALTH</u></p> <p><input type="checkbox"/> Overweight</p> <p><input type="checkbox"/> Underweight</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Tire easily</p> <p><input type="checkbox"/> Night/day sweats</p> <p><u>CARDIOVASCULAR</u></p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Heart skips a beat</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Fast heart rate</p> <p><input type="checkbox"/> Chest pains</p> <p><input type="checkbox"/> Swollen ankles</p> <p><u>FEMALES ONLY</u></p> <p><input type="checkbox"/> Menstrual irregularities</p> <p><input type="checkbox"/> Problem pregnancy</p> <p><input type="checkbox"/> Miscarriage # _____</p> <p><input type="checkbox"/> Abortion # _____</p> <p><input type="checkbox"/> Premenstrual problems</p> <p><input type="checkbox"/> Infertility</p> <p><input type="checkbox"/> Currently pregnant</p> |
|--|---|---|

- Cramps in legs/arms
- Stiff/swollen joints
- Difficulty walking

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