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**

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

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

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

☐ 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**