Adult Personal History

Client Name_____ Date_____

Phone Number: _____ Cell Phone: _____

Address: _____ City: _____ Zip:_____

DOB: _____ Email Address: _____

Why are you seeking counseling?_____

Describe your personal strengths: _____

Marital/Family

# of siblings _____ Birth Order _____

Single Married Separated Divorced Widowed Living together

Hetro-sexual Homosexual Bi-sexual Other

Family Mental Health/Substance Abuse History: _____

_____

Do you have any children or stepchildren? If so list names and ages: _____

_____

Employment

Occupation: _____ Current Employer: _____

Culture and Ethnicity, Spirituality, Religion

What is your religious preference: _____

Does Spirituality influence your life? Y N

List any cultural, ethnic or religious concerns that might affect your treatment: _____

Adult Personal History

Abuse History

Have you ever been physically, sexually or emotionally abused? Y N

Legal

Have you ever been arrested? Y N if yes, please explain: _____

Are you on probation or have a case pending in court? Y N

Recreation/Socialization

Describe your typical daily routine: _____

_____

What recreational activities do you enjoy? _____

Treatment History

Have you been involved in treatment before? Y N If yes:

When: _____ Where: _____ Outcome: Helpful Not Helpful

Mental Health

Indicate if you have any of the following: Depression Frequent fears Guilt Anger Anxiety

Poor Sleep Low self-worth Mood Swings Nervousness Weight concerns Self harming behavior

Do you currently have thoughts of suicide? Y N If yes, please explain:_____

_____

Have you ever attempted suicide or required inpatient hospitalization? Y N If yes, please explain

_____

Do you currently have thoughts of hurting someone else? Y N

Adult Personal History

Substance Use

Do you drink alcohol? Y N Do you use drugs? Y N

Do you have concerns that you may have a problem with alcohol or drugs? Y N

Medical Health History

List any current health concerns: _____

Current Medications (prescribed and over-the-counter)

Medications	Dose	Dates	Side Affects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History of Medical Problems: _____

_____

_____

Patients Signature: _____ Date: _____

Therapist Signature: _____ Date: _____