Personal Information and History

Name: _____ Age: _____
Address:_____ City: _____ State: ____ Zip: _____
Phone: (home)_____ (work) _____
(other)_____ Birth date _____
Spouse/Partner: _____ Age: _____
Marital status:
Never married ____ Married ____Divorced ____ Separated ____Widowed __
(How long? ____

FAMILY HISTORY:

	Father	Mother
Names:	_____	_____
Ages:	_____	_____
Where do they live?	_____	
If deceased, dates:	_____	_____

Brothers and Sisters (oldest to youngest)

Name(s):	Age:	Sex:	Occupation:	Where living:	Deceased?(Y/N)

Your Children: Names:	Age:	Sex:	Grade:	Lives at home?	Step?

PERSONAL HISTORY:

Employment:

Current employer:_____
Length of employment:_____
Job title/duties: _____
Previous experience: _____

Military: Current _____Previous _____ N/A ___
Branch: _____Active duty? _____ Combat?_____
Discharge date:_____Type of discharge:_____

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Education:

Highest grade achieved: _____
Name of College/Vocational School: _____
Degree: _____ Graduate or Professional School: _____

Legal: Current _____ Previous _____ N/A___
Charges: _____ Probation? _____
Court district: _____

Abuse: Current _____ Previous _____ N/A___
Type: Verbal/Emotional _____ Physical _____ Sexual___
Who was/is the abuser(s)? _____
Have you ever abused anyone? _____

Substance abuse: Current _____ Previous _____N/A ___
Past week? _____ Past month? _____ Past year? _____
Type(s): _____
Amount: _____ Frequency: _____
Has alcohol/drug use ever caused a problem? _____ If yes, explain: _____
_____
Have you ever been treated for substance abuse? _____
Have you ever attended a 12-Step Group? _____ If yes, explain: _____
_____
Does anyone in your family have alcohol/addiction problems? _____
Who? _____

Trauma:

List any significant past trauma experienced by you or those close to you (i.e., death, divorce, sickness, crime, etc.) _____
_____
_____

Social History:

How do you generally get along with people? _____
How many close friends do you have? _____
What do you like to do socially,: _____
What leisure activities do you enjoy: _____

Religion:

Religious background: _____
Do you attend a church? _____
Name of church: _____
What part, if any, does God play in your life? _____
_____

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Medical History:

Physician: _____City: _____
Date last seen:_____ Reason:_____
Ongoing medical conditions: _____Allergies: _____
Medication(s): _____
Pregnancies: _____ Live births: _____Other: _____

Previous Mental Health Treatment: Yes _____ No __
Previous counselor(s): _____
How long ago: _____ Where: _____
Treatment for: _____ How many sessions: _____
Other family members in treatment: _____

Current Mental Health Treatment:

Are you seeing another counselor for any reason? _____
Do you have any current suicidal or homicidal thoughts/plan? _____
Past attempts? _____

DAILY ROUTINE:

Eating:

How is your appetite?_____
Any changes in the last six months?_____
Recent weight loss or gain? _____
Problems in eating habits? _____
History of eating disorder? _____ Use of laxatives? _____

Sleeping:

How well do you sleep? _____
Any changes in the last six months?_____
Fall asleep OK? _____Stay asleep?_____
Use of sleep aids? _____
Energy level during the day? _____

Additional Comments or Family Issues?

_____
_____
_____
_____

Your Signature: _____ Date: _____