COUNSELING ASSOCIATES, LLC

Personal History Form

CLIENT NAME: _____ **Preferred Pronoun:** _____ **DATE:** _____

BIRTHDATE: _____ **AGE:** _____ **REFERRAL SOURCE** _____

Form completed by: ☐ Client ☐ Other: _____

Phone number: _____ **Email:** _____

OK to leave message? ☐ Phone ☐ Email

PRESENTING PROBLEM(S) (Issues you are seeking therapy for): _____

- How long have you had the current problem(s)? _____
- How stressful is this to you? Minimal-◉- Mild--○- oderate--○- Severe ○
- How have you attempted to cope with this problem?

_____

What are your symptoms? ☐ sleep disturbance ☐ low interest/motivation ☐ energy level

☐ concentration problems ☐ appetite problems ☐ hopelessness ☐ thoughts of self-harm/suicide

☐ anxiety ☐ panic attacks ☐ nightmares ☐ flashbacks ☐ OCD symptoms ☐ Others:

What effect do these symptoms have on your life? Minimal ◉ Mild ○ Moderate ○ Severe ○

Do you regularly use alcohol? No ○ Yes ○ In a typical month, how often do you have 4 or more drinks? ____

How often do you engage in recreational drug use? Neve.○--Rarely○ Monthly○ Weekly○ Daily○

Do you consider this alcohol/drug use a problem? No ○ Yes ○ Unsure ○

Are there cultural considerations that need to be taken into consideration in your treatment?

○ No ○ Yes Specify: _____

What is your current living situation, employment/school status, marital status? _____

WHAT ARE YOUR PAST/CURRENT/IMPENDING STRESSORS?

☐ Deaths	☐ Divorce	☐ Frequent relocations
☐ Physical/sexual abuse	☐ Alcohol/drug abuse	☐ Psychiatric illness
☐ Attempted/completed suicide	☐ Financial crisis/unemployment	☐ Legal problems
☐ Debilitating injuries/disabilities	☐ Serious illness	☐ Other: _____

HAVE YOU EXPERIENCED ABUSE? ☐ None ☐ Unsure ☐ Emotional ☐ Physical ☐ Sexual

- At what age?
- By whom?

FAMILY OF ORIGIN (parents, siblings, relationships, places lived, family mental health history, substance abuse issues):

In general, how would you describe your childhood? Very happy---Mostly happy---Average---Unhappy---Very unhappy

Why?

Who do you consider a source of support for you?

Medical History: (Current health, allergies, current medications, medical hospitalizations, injuries)

Psychiatric History: (Hospitalizations, outpatient treatments, previous medications)

Other agency/Legal involvement: (Probation, arrests, current court issues, case management)

What do you hope to achieve through treatment?

How optimistic are you that your concern(s) can be addressed? Not at all ○ Mildly ○ Moderately ○ Highly ○