Personal History

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If questions do not apply to you, leave them blank.

Identifying Information

Today's Date: _____

Name: _____ Date of Birth: _____

Partner's Name _____ Date of Birth: _____

Address:_____
Street & Number

_____ _____
City State Zip

Home Phone:_____ Business Phone: _____Cell Phone: _____

Email: _____

Best time to reach you and at which phone number ? _____

Where is it ok to leave messages for you? __ Home __Business __ Cell __ Email

Others living in the home: _____, _____
Name, birthdate, relationship to client Name, birthdate, relationship to client

_____, _____,
Name, birthdate, relationship to client Name, birthdate, relationship to client

Years of education or degree: Self _____ Partner: _____

Occupation: Self: _____ Partner:_____

Employer: Self: _____ Partner: _____

Social Security Number: Self: _____ Partner: _____

Present Marital Status: _____

Emergency contact: _____
Telephone: _____

Who referred you or how did you hear about my services?
_____
_____
_____

Insurance Information:

Client's Name: _____ Client's Date of Birth: _____

Name of Insured: _____ Insured's Date of Birth: _____

Address of Insured Person: :_____
Street & Number

____ _____ _____
City State Zip

Relationship of Client to Insured Person: _____

Employer of Insured Person: _____

Insurance Company Name: _____
Address: _____
City, State, Zip: _____

Specific Insurance Plan Name: _____

Phone Number for Claims: _____

Insurance Identification Number: _____ Group Number: _____

Are you seeking help due to:
Employment? Yes or No ___ Auto Accident Yes or No ___ Other Accident? Yes or No ___

Secondary Insurance: _____ Phone: _____

Name of Secondary Insured: _____ Date of Birth: _____

Secondary Company Address: _____ City, State, Zip: _____

Secondary Identification Number: _____ Group Number: _____

For Office Use

Date of Service: _____ Diagnosis: _____
CPT Code: _____
Prior Balance and Description of Arrangements Made: _____

_____

_____

Payment Information: _____

_____

_____

_____

Counseling History

What are your main reasons for this visit?: _____
_____
_____
_____
_____
_____
_____
_____

Are you receiving counseling services from anyone else at present?: Yes____No____
If Yes, please briefly describe:
_____
_____

Have you received counseling in the past?: Yes_____ No_____ If Yes, please briefly describe your experience and the results:
_____
_____

Medical History:

Name and address of your primary physician:
Physician's name: _____

Address: _____

Telephone: _____

List any major illnesses and/or operations you have had:_____
_____
_____

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, pain, etc):

_____
_____
_____
_____

When was your most recent complete physical exam?:_____

Results of physical exam: _____
_____

Have you gained/lost over ten pounds in the past year?: __Yes __No, __gained __lost
If Yes, was the gain/loss on purpose?: __Yes __No

Describe your appetite (during the past week):
_____ poor appetite _____ average appetite _____ large appetite

What medications (and dosages) are you taking at present, and for what purpose?:
Medication Purpose
_____
_____
_____
_____

Symptoms

Check any Problems that Describe Your Childhood

- ❑ Violence
- ❑ Theft
- ❑ Persistent Lying
- ❑ Truancy
- ❑ Fire Starting
- ❑ Sexual Behavior
- ❑ ADHD (Attention Deficit)
- ❑ Trauma _____
- ❑ Cruelty to Animals
- ❑ Vandalism
- ❑ Classroom Disruption
- ❑ Substance Abuse
- ❑ Bedwetting
- ❑ Learning Disabilities
- ❑ Fetal Alcohol Syndrome
- ❑ Bullying
- ❑ Being Bullied
- ❑ Suspended, Expelled from School

Check the behaviors and symptoms that occur to you more often than you would like them to

- _____ aggression
- _____ alcohol dependence
- _____ anger
- _____ antisocial behavior
- _____ anxiety
- _____ avoiding people
- _____ chest pain
- _____ depression
- _____ disorientation
- _____ distractibility
- _____ dizziness
- _____ drug dependence
- _____ eating disorder
- _____ elevated mood
- _____ fatigue
- _____ hallucinations
- _____ heart palpitations
- _____ hopelessness
- _____ impulsivity
- _____ insomnia
- _____ irritability
- _____ judgment errors
- _____ loneliness
- _____ memory impairment
- _____ mood shifts
- _____ panic attacks
- _____ phobias/fears
- _____ recurring thoughts
- _____ sexual difficulties
- _____ sick often
- _____ sleeping problems
- _____ speech problems
- _____ suicidal thoughts
- _____ thoughts disorganized
- _____ trembling
- _____ withdrawing
- _____ worrying
- _____ other (specify)
- _____
- _____
- _____
- _____

Substance Use:

Name of Drug	Most Frequent Use (How much and when)	Date of Last Use	Age at the Time of First Use
Alcohol			
Marijuana			
Amphetamine			
Cocaine			
Other:			
Other:			

Have you been, or are you in treatment for drug or alcohol problems?_____
Where, when:
_____
_____
_____

Family/Relationship History: Please give a brief history of the family you grew up in, your adult intimate relationships and themes that have been present:

List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

Additional information you believe would be helpful:_____

PLEASE BRING THIS AND OTHER ASSESSMENT MATERIALS TO YOUR APPOINTMENT