

906 Webb Street NE  
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## ***Personal History***

*Please complete this form thoughtfully to help us work together more effectively.*

Name \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

\_\_\_\_\_ Work Phone: \_\_\_\_\_

OK to call at home? Yes / No At work? Yes / No OK to leave message at home? Yes / No At work? Yes / No

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Are you allergic to dogs?  Yes  No Are you afraid of dogs?  Yes  No

**Current living situation:**  Alone  W/Roommates  W/Parents  W/Children  With Spouse/Partner

Name: \_\_\_\_\_ M / F Age: \_\_\_\_\_ Special Needs: \_\_\_\_\_

Name: \_\_\_\_\_ M / F Age: \_\_\_\_\_ Special Needs: \_\_\_\_\_

Name: \_\_\_\_\_ M / F Age: \_\_\_\_\_ Special Needs: \_\_\_\_\_

Name: \_\_\_\_\_ M / F Age: \_\_\_\_\_ Special Needs: \_\_\_\_\_

Pets: \_\_\_\_\_

**Parents, brothers, sisters, and adult children not living with you:**

<u>Name</u>	<u>Age</u>	<u>Where Living</u>	<u>Special Needs or Illnesses</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Losses you have experienced** (OK to include pets as well as people):

<u>Name</u>	<u>Relationship</u>	<u>When</u>	<u>Circumstances</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is your support system? \_\_\_\_\_

Name: \_\_\_\_\_

What do you do for recreation/relaxation? \_\_\_\_\_

I drink approximately \_\_\_\_\_ glasses of alcohol a week. A family member is alcoholic.  Yes  No

What is your church or religious belief? \_\_\_\_\_

How important is spirituality in your life right now?

- Extremely Important
- Very Important
- Sort of Important
- Not Very Important
- Not Important at All

When you were growing up, how did your family deal with conflict? (Check all that apply.)

- Tease
- Yell
- Spank
- Hit
- Shame
- Discussion
- Withdraw
- Deny
- Guilt
- Threats
- Alcohol/Drugs
- Eat
- Other: \_\_\_\_\_

In your situation now, how do you deal with conflict at home? (Check all that apply.)

- Tease
- Yell
- Spank
- Hit
- Shame other person
- Feel ashamed
- Discussion
- Withdraw
- Deny
- Guilt other person
- Feel Guilty
- Eat
- Use Alcohol/Drugs
- Make Threats
- Other: \_\_\_\_\_

When you were growing up, did your parents show physical affection between themselves?  Yes  No

When you were growing up, were your parents verbally or physically affectionate with you?  Yes  No

Have you ever been verbally, physically, sexually, or emotionally abused?  No  Yes (circle which one[s])

Are you being verbally, physically, sexually, or emotionally abused now?  No  Yes (circle which one[s])

How many hours a night do you sleep? \_\_\_\_\_

Do you ever have trouble sleeping through the night?  Yes  No What do you do? \_\_\_\_\_

What concerns do you have about your physical health?

What significant health concerns have you had in the past?

Medications:

Medication	Dosage	How Long	Who Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal/natural remedies are you taking? \_\_\_\_\_

If you are married or in a long-term relationship, how long have you been a couple? \_\_\_\_\_

What is your partner's age? \_\_\_\_\_ Occupation? \_\_\_\_\_

What is your partner's pattern of alcohol or drug use? \_\_\_\_\_

How satisfied are you with your relationship?

- Thrilled – it's the best thing in my life.
- We've got our problems, but we're better than average.
- It's OK, I guess.
- This relationship is really hard – maybe too hard to stay in.
- I want out!

Name: \_\_\_\_\_

Please check the symptoms that match your experience:

- |  |   |
|--|---|
| <input type="checkbox"/> I feel depressed most of the day.   | <input type="checkbox"/> I have trouble controlling my worry.                 |
| <input type="checkbox"/> I lack interest in most activities.   | <input type="checkbox"/> I feel restless or on edge.                          |
| <input type="checkbox"/> My appetite has changed (more/less).  | <input type="checkbox"/> I'm irritable.                                       |
| <input type="checkbox"/> My sleep has changed (not enough/too much).   | <input type="checkbox"/> My muscles are tense.                                |
| <input type="checkbox"/> I don't have much energy.   | <input type="checkbox"/> I have times of intense fear or panic.               |
| <input type="checkbox"/> I feel of worthless or guilty.  | <input type="checkbox"/> I'm afraid of being outside my home alone.           |
| <input type="checkbox"/> I have trouble concentrating or making decisions.   | <input type="checkbox"/> I'm afraid to be in a crowd alone.                   |
| <input type="checkbox"/> I'd like to die, or I think about committing suicide.   | <input type="checkbox"/> I have recurring thoughts that cause anxiety/stress. |
| <input type="checkbox"/> I'm more talkative than usual.  | <input type="checkbox"/> I've had recurring distressing memories.             |
| <input type="checkbox"/> I've drunk 6 or more drinks at one time.  | <input type="checkbox"/> My thoughts race.                                    |
| <input type="checkbox"/> I'm easily distracted.  | <input type="checkbox"/> I have trouble sitting still.                        |
| <input type="checkbox"/> I've been repeating actions (hand washing, checking, counting, repeating words, etc.)   |   |
| <input type="checkbox"/> I've gotten involved in activities that are fun but that might cause trouble later (spending sprees, sexual indiscretions, anger outbursts, etc.) |   |
| <input type="checkbox"/> I feel the need or I wonder if I should cut down on my use of drugs or alcohol.   |   |

Please comment on any of those that you want me to know more about:

Name: \_\_\_\_\_

What is your biggest fear or concern about working with a counselor?

What issues are important to you? Mention any ambitions, difficulties, obstacles, etc., even if they seem unimportant.

How long have these issues been important? \_\_\_\_\_

What things have you already tried to work on them?

In the past two years, have you had:  Counseling  Psychiatric Care  Psychiatric Hospitalization

If so, what were the issues, and did you feel like the treatment helped?

Do any family members suffer from mental illness?  No  Yes Who? \_\_\_\_\_

What is your reason for seeking counseling at this time (if different from what you described above)?

How will you know that this counseling has been successful? What will be different in your life?