4705 Lacey Boulevard, Ste. D
Lacey, WA 98503-5712

ANN R. HOWIE, LICSW, ACSW

Voice: 360-493-2586
FAX: 360-455-1318

Personal History

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

Name _____ Age: _____ Date: _____

Address: _____ Cell/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

OK to send you an e-mail? Yes / No E-Mail: _____

Occupation: _____ Employer: _____

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

How did you hear about me? _____

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:

Name	Age	Where Living	Special Needs or Illnesses

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

Name	Relationship	When	Circumstances

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:

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

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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?

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