

Personal History: Adults

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

Name of person completing form (if different from client) \_\_\_\_\_

Date of Birth \_\_\_\_\_ age: \_\_\_\_\_

Gender CIRCLE ONE) Female Male

Please list the reasons/concerns that brought you here today.

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What is the highest level of education you achieved (i.e. GED, high school diploma, BS, PhD) \_\_\_\_\_

List job history (Begin with most recent job,)

Employer	Dates	Job Title	Reason left job	How often miss work

If you are currently employed, how happy are you with your current employment? CIRCLE ONE

- 1 Very unhappy
- 2 Unhappy
- 3 Neutral
- 4 Happy
- 5 Very Happy

Military Experience? CIRCLE ONE YES NO

If Yes

Branch: Years of service:(# of years) \_\_\_\_\_

Combat Experience CIRCLE ONE YES NO

Do you have any religious or spiritual beliefs or practices? If so please describe\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family History

List everyone with whom you currently live?

\_\_\_\_\_

How would you describe your relationship with these people?

- (1)\_\_\_\_\_
- (2)\_\_\_\_\_
- (3)\_\_\_\_\_
- (4)\_\_\_\_\_

How many times have you been married? \_\_\_\_\_

(Please list names of spouse(s) and dates of marriage and divorce if applicable)

\_\_\_\_\_  
:  
\_\_\_\_\_  
\_\_\_\_\_

If you are currently married or involved in a romantic relationship: How would you rate your current relationship? CIRCLE ONE

Excellent Good Fair Poor

Please fill in information below.

<u>Relationship</u>	<u>Age</u>	<u>Highest level of education</u>	<u>Occupation</u>	<u>Marital Status (Single, Married, Divorced, Widowed, Remarried)</u>
Spouse/Significant Other				
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				

Has anyone in your family (include parents, children, siblings, aunts, uncles, grandparents) been diagnosed with an emotional or psychological issues (e.g. depression, anxiety, suicide, drug and alcohol problems)

CIRCLE ONE YES NO

IF YES please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you have children please complete information below.

<u>Children</u>	<u>Age</u>	<u>Grade</u>	<u>Live with you</u>


Development

Are there any special, unusual, or traumatic circumstances that affected your development?\_

CIRCLE ONE YES NO

IF YES please describe:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check all that apply during your childhood and adolescence

\_\_\_ Sexual Abuse    \_\_\_ Physical Abuse    \_\_\_ Emotional abuse    \_\_\_ Neglect    \_\_\_ Poor Nutrition

\_\_\_ Learning Problems    \_\_\_ Social Problems    \_\_\_ Behavioral Problems    \_\_\_ School problems    \_\_\_ Legal Problems

\_\_\_ Other (Please Specify)\_\_\_\_\_

Health History

Please rate your overall health (CIRCLE ONE)

Excellent    Good    Fair    Poor

List Current Health Concerns \_\_\_\_\_

List any recent health or physical changes:\_\_\_\_\_

\_\_\_\_\_

Please describe your habits

Substance	Method of use and amount	Freq of use	Age first use	Age last use
Alcohol				
Tobacco				
Caffeine				
Street Drugs (e.g. marijuana, cocaine)				

### Psychological History

How many close friends do you have? \_\_\_\_\_

How often do you socialize with your friends? (CIRCLE ONE)

Very Often   Often   Sometimes   Rarely

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How satisfied are you with your weight and appearance? CIRCLE ONE

Very Satisfied   Satisfied   Neutral   Dissatisfied   Very Dissatisfied

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Do you have any thoughts of harming yourself at this time? CIRCLE ONE   Yes  
No

Do you have any thoughts of harming someone else at this time? CIRCLE ONE   Yes  
No

Please check if there have been any recent changes in the following:

\_\_\_ Sleep Patterns   \_\_\_ Eating patterns   \_\_\_ Behavior   \_\_\_ Energy Level

\_\_\_ Physical Activity   \_\_\_ General mood   \_\_\_ Weight   \_\_\_ Nervousness/tension

Describe changes in area in which you checked above \_\_\_\_\_

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Any additional information that would assist in understanding your concerns or problems? \_\_\_\_\_

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What are your goals for therapy? \_\_\_\_\_

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