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PERSONAL HISTORY FORM

❑ **Adult** ❑ **Child**

First name: _____ Last name: _____

Preferred name/nickname: _____

DOB: _____ SSN: _____

Address: _____

City/State/Zip: _____

Home phone: _____ Cell phone: _____

Race: _____ Religion: _____

Referred by: _____

Date current symptoms or issues began: _____

Frequency of symptoms:	❑ Monthly	❑ Weekly	❑ Hourly	❑ Constant
Scale of 1-10:				

Symptoms: (please check all that apply)

❑ Depression	❑ Anxiety	❑ Sexual issues
❑ Crying spells	❑ Panic attacks	❑ Financial issues
❑ Lack of concentration	❑ Guilt/Shame	❑ Alcohol use
❑ Confusion	❑ Hopelessness	❑ Drug use
❑ Mood swings	❑ Relationship problems	❑ Gambling
❑ Racing thoughts	❑ Relationship break up	❑ Spending
❑ Job stress	❑ Loneliness	❑ Visual hallucinations
❑ Fear of dying	❑ Sleep disturbance	❑ Auditory hallucinations
❑ Decreased activity	❑ Nightmares	❑ Feeling controlled
❑ Decreased self-care	❑ Unusual thoughts	❑ Social isolation

Past Psychiatric History:

Prior treatment?	❑ Yes	❑ No
If yes, when and where?		
Have you been hospitalized for symptoms in the past?	❑ Yes	❑ No
If yes, when and where?		
Have you ever attempted suicide?	❑ Yes	❑ No
If yes, when?		

Trauma History:

Have you ever been a victim of abuse?			
Mental	❑ Yes	❑ No	Age?
Physical	❑ Yes	❑ No	Age?
Sexual	❑ Yes	❑ No	Age?
Emotional	❑ Yes	❑ No	Age?

Family Psychiatric History:

Is there any psychiatric history with any family member listed below?			
Mother	❑ Yes	❑ No	Diagnoses:
Father	❑ Yes	❑ No	Diagnoses:
Siblings	❑ Yes	❑ No	Diagnoses:
Grandmother	❑ Yes	❑ No	Diagnoses:
Grandfather	❑ Yes	❑ No	Diagnoses:
Extended family	❑ Yes	❑ No	Diagnoses:

Medical Conditions and History:

Current or past medical issues?	❑ Yes	❑ No
Please list:		

Current medications:			
Name:	Dosage (mg)	Frequency (x per day)	Prescribing MD

Conditions			**Current**	**Past**
Allergies	❑ Yes	❑ No		
Asthma	❑ Yes	❑ No		
Ulcers	❑ Yes	❑ No		
Seizures	❑ Yes	❑ No		
Stomach problems	❑ Yes	❑ No		
Insomnia	❑ Yes	❑ No		
Vision problems	❑ Yes	❑ No		
Hearing problems	❑ Yes	❑ No		
Diabetes	❑ Yes	❑ No		
High blood pressure	❑ Yes	❑ No		
Heart disease	❑ Yes	❑ No		
Weight gain/obesity	❑ Yes	❑ No		
Appetite disturbance	❑ Yes	❑ No		
STD	❑ Yes	❑ No		
Cancer	❑ Yes	❑ No		
Major surgeries	❑ Yes	❑ No		
Major accidents	❑ Yes	❑ No		
Neck/shoulder tension	❑ Yes	❑ No		
Headaches/migraines	❑ Yes	❑ No		
Chronic pain	❑ Yes	❑ No		
Irritable bowel	❑ Yes	❑ No		
Impotence	❑ Yes	❑ No		
Sexual issues	❑ Yes	❑ No		

Substance Use/Abuse	Age first used	Last use	Amount/frequency
❑ Alcohol			
❑ Cigarettes			
❑ Marijuana			
❑ Prescription drugs			
❑ Other			

Family History		
Were your parents divorced?	❑ Yes	❑ No
If yes, how old were you?		
Who were you raised by?		
Do you have siblings?	❑ Yes	❑ No
Names:	Ages:	Sex:
Are you married?	❑ Yes	❑ No
If so, how long?		
Number of marriages:		
Social History		
Most significant relationships:		

Do you have good social support/friends?	❑ Yes	❑ No
Do you consider your relationship with other as close?	❑ Yes	❑ No
Developmental History		
Did you experience typical developmental stages as a child?	❑ Yes	❑ No
Did you have learning difficulties as a child?	❑ Yes	❑ No
Did you have to repeat grades or schooling?	❑ Yes	❑ No
Educational/Occupational History		
Did you graduate from high school?	❑ Yes	❑ No
Highest level of education:		
Career/employment/time with company:		

Legal History		
Any arrests?	❑ Yes	❑ No
If so, for what reason?		
Have you ever been incarcerated?	❑ Yes	❑ No
Any current legal difficulties?	❑ Yes	❑ No
If yes, please explain:		
Personal		
Strength:		
Needs:		
Abilities:		
Treatment requests:		

Client signature: _____ Date: _____

Therapist signature: _____ Date: _____