

PERSONAL HISTORY QUESTIONNAIRE

PURPOSE: Please print all your responses in ink and do not leave any blanks. This questionnaire is designed to collect your relevant psychological, sociological, and medical information. This information is used to better understand how to serve you, so that you might learn to problem-solve and cope more effectively in the future. It is important to respond as honest and accurate as possible in order for your counselor to develop a reliable picture of your situation and concerns. If you do not want to answer a question, please write "I do not want to answer that now" in the space provided for your answer. Just guess the season and year for dates you do not remember. Your counselor will review this form with you and retain it along with your other confidential records. Print. Thank you.

SECTION I: Client Identification

DATE: _____ SOCIAL SECURITY NUMBER: _____ COUNSELOR: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

DATE OF BIRTH: _____ CURRENT AGE: _____ BIRTH PLACE: _____

RACE: _____ SEX: male female SCARS: _____MARITAL STATUS: never married cohabitating engaged married separated divorced widowed

HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ HAIR COLOR: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

REFERRAL SOURCE: _____ PREVIOUS ADMISSIONS: none yes NUMBER OF: _____

EMERGENCY CONTACT: _____ EMERGENCY CONTACT'S PHONE: _____

SECTION II: Presenting Problems

What brings you to counseling now? _____

What would your spouse, friends, family, parents, and-or the referral source say brings you to counseling? _____

Have the problems **affected** your: work functioning family relations home environment friendships
 social activities legal complications spiritual activities caused thinking changes feeling changes
 caused behavior changes caused physical changes caused any other changes?

PROVIDE DETAILS: _____

How **severe** are the **problems** to you on a scale of 1 to 10 with 10 being the worst? 1 2 3 4 5 6 7 8 9 10How severe are the **problems** to you on the word scale below? uncomfortable irritating annoying upsetting disturbing horrible unbearable can't stand itHow would you rate your **motivation to change** on a scale of 1 to 10 with 10 being the highest? 1 2 3 4 5 6 7 8 9 10How would you rate your **motivation to change** on the word scale below? none not much average a lot too muchWhen did the problems first **begin**? Please give dates (or season of the year) and events.What was going on just **before** the problems first began?

What were the major life changes near the start of the problem?

When have **similar** problems occurred?What have you done in the past to **handle** similar problems?What has **worked** to help with these problems?What has **not worked** to help with these problems?How will everything **be different** when the problems are gone?What do you want to **improve** first?

YES	NO	STRESSOR	YES	NO	STRESSOR
y	n	age milestone 20/30/40/50/60/70	y	n	death of close family member
y	n	begin or end school	y	n	death of close friend
y	n	change in any major patterns	y	n	death of spouse
y	n	change in arguments with significant	y	n	detention in institution
y	n	change in behavior of family member	y	n	divorce
y	n	change in business	y	n	fired from job
y	n	change in church activities	y	n	foreclosure of loan
y	n	change in eating habits	y	n	getting married
y	n	change in financial state	y	n	hospitalization for illness/injury
y	n	change in health of family member	y	n	in-law problems
y	n	change in living conditions	y	n	loan greater than \$10,000
y	n	change in number of family events	y	n	marital reconciliation
y	n	change in recreation	y	n	marital separation
y	n	change in residence	y	n	minor law violation
y	n	change in sleep pattern	y	n	mortgage greater than \$10,000
y	n	change in social activities	y	n	moving
y	n	change in work conditions	y	n	new person living with you
y	n	change in work duties	y	n	outstanding personal accomplishment
y	n	change in work hours	y	n	pregnancy
y	n	change of personal habits	y	n	retirement
y	n	change of schools	y	n	sexual problems
y	n	change of work	y	n	spouse beginning/ceasing work
y	n	child leaving home	y	n	stressful job
y	n	Christmas	y	n	transportation problems
y	n	conflict with boss	y	n	vacation

What is in the way of your solutions to these problems such as stressors, obstacles, pressures, and-or challenges?

Have you ever had professional help with any of these problems before? Please list the last three if more than three.

1) WHO: _____ WHERE: _____ WHEN: _____ HOW LONG: _____

WHAT RESULTS: _____

2) WHO: _____ WHERE: _____ WHEN: _____ HOW LONG: _____

WHAT RESULTS: _____

3) WHO: _____ WHERE: _____ WHEN: _____ HOW LONG: _____

WHAT RESULTS: _____

What is your **view of counseling**? Please check all that apply.

- support for your point of view
- protection from others or the world
- permission to do what you want/need
- permission to change
- power to change
- supportive friendship/listening
- role model for improved living
- opportunity to gain insight into your motives
- help to change habits
- education/insight about relationships
- support for switching from ineffective behaviors
- learning new skills
- education/insight about emotions

What is your view of the **source of your problems**? Please check all that apply.

- I do not have any problems
- others have problems
- others cause my problems
- life causes my problems
- I contribute to my problems
- I'm the cause of my problems
- I want to change others
- I want to change me
- I want to change my life
- I want to rewrite my life
- I want to relearn coping and problem-solving

What is your view of the best way to **deal with your problems**? Please check all that apply.

- best to ignore them
- best to forget them
- best to exchange them
- excuse your behaviors because of them
- best to cope with them
- best to problem-solve them
- find out who caused them
- stop those who cause them
- punish those who cause them
- you learned them
- you can unlearn them
- you can learn to do differently
- I am doing the best I can with the skills I have
- learn new coping skills
- learn new problem-solving skills

Who were you raised by? From when to when?

Were they your biological parents? yes no

HOW CLOSE WAS YOUR FAMILY THEN: far apart somewhat close close very close too close

HOW DID THEY RESPOND TO CHANGES: things just happened took things as they came planned for change
 resisted change denied change

What are the names, ages, and living locations of your **fathers**?

How did you get along with your fathers growing up and now?

What was your father's occupation while you were growing up and now?

What are the names, ages, and living locations of your **mothers**?

How did you get along with your mothers growing up and now?

What was your mother's occupation while you were growing up and now?

What are the names, ages, and living locations of your **brothers**?

How did you get along with your brothers growing up and now?

What are the names, ages, and living locations of your **sisters**?

How did you get along with your sisters growing up and now?

What are the names, dates, ages, and cities of your **marriages or partners**?

What were the dates and reasons for **divorces** and/or major **breakups**?

What are the names, dates of birth, and living locations of your **children** including stepchildren?

How were the **rules** maintained or enforced (types of punishments) when you were growing up?

Are any family members **cutoff**, blocked, or disowned from any other members?

Are any family members ganging up on, picking on, or **attacking** any other family members?

What is the **health** of the members of your family of origin?

If any family members have **died**, please report the dates and causes of death.

What was your age and **response** to the death of each family member who died?

Do you consider yourself to be of any particular **race** or ethnic group?

In what ways is membership in this race or ethnic group **important** to you?

What **religious** or spiritual training were you given as a child?

What religious or spiritual **training** do you seek now and-or find important now?

Does your membership in this race or **ethnic** group have anything to do with your problems?

When **growing up**, did you have any problems with any of the following?

delayed development? yes no crawling? yes no walking? yes no talking? yes no

do not know or DETAILS: _____

Did you experience any **abuse** while growing up?

not being properly cared for (neglect)? yes no physical abuse? yes no sexual abuse? yes no

verbal abuse? yes no emotional abuse? yes no other forms of abuse? yes no

What **problems** did you have growing up? Check the boxes and explain any check mark answers afterward.

school? yes no grades? yes no skipped school? yes no home? yes no church? yes no

runaway? yes no pregnancy? yes no fire setting? yes no lying? yes no fights? yes no

used weapons in fights? yes no destruction of property? yes no cruelty to animals? yes no

Have you had any special education classes? yes no learning disabilities? yes no handicaps? yes no

EXPLAIN: _____

How did you get along with **grade school** teachers? terrible poor average good great

How did you get along with **high school** teachers? terrible poor average good great

How did you get along with **college** teachers? terrible poor average good great

How did you get along with **grade school** students? terrible poor average good great

How did you get along with **high school** students? terrible poor average good great

How did you get along with **college** students? terrible poor average good great

What was your **grade average** in grade school? terrible poor average good great

What was your grade average in high school? terrible poor average good great

What was your grade average in college? terrible poor average good great

Please list all degrees, trade schools, certificates, and training programs attempted and completed with dates:

What current and-or **future** schooling plans do you have?

Did you have any jobs to make money as a child? neighborhood jobs shoveling snow selling lemonade

odd jobs gardening paper route car washing raking leaves other

PROVIDE DETAILS: _____

What is your adult work history? Please include types and numbers of jobs.

What kinds of work have you enjoyed?

What is your current employment?

What are your future plans for employment?

Have you ever been fired from a job? yes no How many times? _____

Have you ever quit a job? yes no How many times? _____

What are your job skills? _____

What is your job security if any? _____

Have you ever served in the military? yes no

BRANCH: _____ SEEN COMBAT: _____ PAY GRADE: _____ DATES OF SERVICE: _____

DISCHARGE STATUS: _____ DUTY: _____

Are you currently in a **sexual relationship**? yes no Is it satisfactory? yes no page 5 of 7

What is your past sexual orientation? heterosexual homosexual bisexual asexual celibate

What is your present sexual orientation? heterosexual homosexual bisexual asexual celibate

What is your future sexual orientation? heterosexual homosexual bisexual asexual celibate

How did you first learn about sex? _____

When did you first become sexually active? _____

Have you ever been forced to have sex? _____

Have you ever paid for sexual favors? _____

Are you experiencing any loss of sexual desire or ability to perform? _____

What is the date of your menstruation or menopause? _____

How many close friends do you have? (Close being, for example, someone who would loan you \$100 and listen to you whine for an hour.) none a few several many a lot

Do you have any close relatives in the area? yes no Are they part of your support system? yes no

Are you involved in your community in any way? yes no

What are your hobbies, interests, and leisure time activities? _____

Do you belong to any groups? yes no

Have you ever belonged to any groups that were hard to leave, controlling, or punishing? yes no

What is your current living situation?

apartment home condo buying renting number of bedrooms: 1 2 3 more

Who lives with you? _____

What is the source of your income and are there any financial concerns? _____

What insurance do you carry? health disability retirement life homeowner's renter's

Have you ever been arrested? yes no

REASON: _____ CHARGES: _____ DATES: _____ SENTENCES: _____

OUTCOMES: _____ JAIL: _____ PRISON: _____ PROBATION: _____ PAROLE: _____

REASON: _____ CHARGES: _____ DATES: _____ SENTENCES: _____

OUTCOMES: _____ JAIL: _____ PRISON: _____ PROBATION: _____ PAROLE: _____

REASON: _____ CHARGES: _____ DATES: _____ SENTENCES: _____

OUTCOMES: _____ JAIL: _____ PRISON: _____ PROBATION: _____ PAROLE: _____

Are there any current legal concerns? _____

Are you court ordered to treatment? _____

Describe yourself with single words or short phrases: strengths, weaknesses, self-worth.

SECTION IV: Health History

Who is your physician, family doctor, or clinic (name, address, phone)? _____

When was the last time you saw them and what for? _____

Do you have any mental or physical **disabilities**? _____

Is there a family history of medical concerns? cancer high blood pressure heart disease genetic other
PROVIDE DETAILS: _____

Is there a **family history** of mental-health problems? depression anxiety nervous breakdowns
 hospitalizations suicide attempts other DETAILS: _____

Do you eat 5 servings of fruits and vegetables almost every day? yes no

Do you eat at about the same times each day? yes no

Have you experienced any recent **weight gain** or loss? yes no If yes then how much? _____

Do you enjoy eating? yes no

How do you get your exercise? _____

How many hours of **sleep** do you normally get? 4 5 6 7 8 9 10 11 12 hours

Do you normally take **naps** and for how long? yes no 1 2 3 4 hours

Do you experience frequent waking or tossing and turning? yes no If yes then how often? _____

How would you rate your **energy level** on a scale from 1 to 10 with 10 being the highest?

1 2 3 4 5 6 7 8 9 10

How would you rate your **energy level** on the word scale below?

none not much average a lot too much

How would you rate your **activity level** on a scale from 1 to 10 with 10 being the highest?

1 2 3 4 5 6 7 8 9 10

How would you rate your **activity level** on the word scale below?

none not much average a lot too much

How would you rate your **enjoyment level** on a scale from 1 to 10 with 10 being the highest?

1 2 3 4 5 6 7 8 9 10

How would you rate your **enjoyment level** on the word scale below?

none not much average a lot too much

How would you rate your **health** on a scale from 1 to 10 with 10 being the highest?

1 2 3 4 5 6 7 8 9 10

How would you rate your **health** on the word scale below?

terrible poor average good great

Why did you rate your **health** the way that you did?

Are you very concerned about any physical problems or symptoms?

Are you allergic to or have you ever had an allergic reaction to any medications?

Are you sensitive to or have you ever had any negative reactions to any medications?

List all prescribed medications taken in last 6 months. Already reported on intake medication sheet: yes no

List all over-the-counter medications that you take. Already reported on intake medication sheet: yes no

After answering “yes” or “no” for all the following, please provide more information on all your “yes” answers.

YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION
y	n	Aids	y	n	Head Injuries	y	n	Pneumonia
y	n	Allergies	y	n	Headaches	y	n	Polio
y	n	Arthritis	y	n	Heart Disease	y	n	Problematic Childbirth
y	n	Asthma	y	n	Herpes	y	n	Prostatitis
y	n	Back Pain	y	n	High Blood Pressure	y	n	Respiratory Infections
y	n	Boils/Rashes	y	n	Hospitalizations	y	n	Rheumatic Fever
y	n	Brain Injuries/Trauma	y	n	Impaired Circulation	y	n	Seizures
y	n	Broken Bones	y	n	Infections	y	n	Severe Vomiting
y	n	Convulsions	y	n	Irregular menstrual cycle	y	n	Shortness of Breath
y	n	Dermatology/skinproblem	y	n	Jaundice	y	n	Sleeping Sickness
y	n	Diabetes/Sugar intolerant	y	n	Kidney Disease	y	n	Spinal Cord Injuries
y	n	Disorientation	y	n	Nervous Condition	y	n	Spinal Meningitis
y	n	Dry Mouth	y	n	Neurological Problems	y	n	Stitches
y	n	Emergency Room Visits	y	n	Nose/Gums Bleeding	y	n	Strep Throat
y	n	Encephalitis	y	n	Operations	y	n	Syphilis or other STDs
y	n	Exposure to CNS Toxins	y	n	Others Not Mentioned	y	n	Tonsillitis
y	n	Fainting/Dizziness	y	n	Painful Menstrual Cycle	y	n	Tuberculosis
y	n	Gastrointestinal Concerns	y	n	Palpitations	y	n	Unconsciousness
y	n	Gonorrhea	y	n	Persistent Chest Pain	y	n	Unusual/heavy bleeding
y	n	Gout	y	n	Persistent Pain	y	n	Urinary Tract Infection

Have you had any significant **accidents** or illnesses that were not covered above? Please explain.

At what age did you start to use caffeine (coffee, tea, or caffeinated pop)? _____

What was your childhood usage like? _____

What is your adult usage like? _____

At what age did you start to use nicotine (tobacco, chew)? _____

What was your childhood usage like? _____

What is your adult usage like? _____

At what age did you start to use alcohol? _____

What was your childhood usage like? _____

What is your adult usage like? _____

At what age did you start to use marijuana? _____

What was your childhood usage like? _____

What is your adult usage like? _____

At what age did you start to use illegal drugs and which ones? _____

What was your childhood usage like? _____

What is your adult usage like? _____

Have you ever had a DWI or OWI? yes no

DETAILS: _____

Have you ever had any drug or alcohol evaluations or treatments? yes no

If "yes" then when, where, and with what outcomes or completions? _____

Have you ever felt that you should cut down on your drinking or drugging? yes no

DETAILS: _____

Have people annoyed you by criticizing your drinking or drugging? yes no

DETAILS: _____

Have you ever felt bad or guilty about your drinking or drugging? yes no

DETAILS: _____

Have you ever had a drink or a drug first thing in the morning to steady your nerves or to get over a hangover?

yes no DETAILS: _____

Have you ever been to support groups such as AA, NA, CA, GA, OA, Al-Anon? yes no

Do you now or have you had in the past any compulsions that you could not control such as eating, gambling, sexing, spending, interneting, shoplifting? yes no

DETAILS: _____

Is there anything you would like to add to your social history now that you are at the end?

Client's Signature

Date Signed