**COUNSELING ASSOCIATES, LLC**

**Personal History Form**

**CLIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE:** \_\_\_\_\_\_\_\_\_\_\_ **REFERRAL SOURCE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form completed by: [ ] Client [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OK to leave message?** [ ] Phone [ ] Email

**PRESENTING PROBLEM(S)** (Issues you are seeking therapy for):

* How long have you had the current problem(s)?
* How stressful is this to you? Minimal----------Mild----------Moderate----------Severe
* How have you attempted to cope with this problem?

**What are your symptoms?** [ ] sleep disturbance [ ] low interest/motivation [ ] energy level

[ ] concentration problems [ ] appetite problems [ ] hopelessness [ ] thoughts of self-harm/suicide

[ ] anxiety [ ] panic attacks [ ] nightmares [ ] flashbacks [ ] OCD symptoms [ ] Others:

**What effect do these symptoms have on your life?** Minimal----------Mild----------Moderate----------Severe

**Do you regularly use alcohol?** No Yes In a typical month, how often do you have 4 or more drinks? \_\_\_\_\_

**How often do you engage in recreational drug use?** Never----Rarely----Monthly----Weekly----Daily

**Do you consider this alcohol/drug use a problem?** No Yes Unsure

**Are there cultural considerations that need to be taken into consideration in your treatment?**

[ ] No [ ] Yes Specify:

**What is your current living situation, employment/school status, marital status?**

**WHAT ARE YOUR PAST/CURRENT/IMPENDING STRESSORS?**

[ ] Deaths [ ] Divorce [ ] Frequent relocations

[ ] Physical/sexual abuse [ ] Alcohol/drug abuse [ ] Psychiatric illness

[ ] Attempted/completed suicide [ ] Financial crisis/unemployment [ ] Legal problems

[ ] Debilitating injuries/disabilities [ ] Serious illness [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU EXPERIENCED ABUSE?** [ ] None [ ] Unsure [ ] Emotional [ ] Physical [ ] Sexual

* At what age?
* By whom?

**FAMILY OF ORIGIN** (parents, siblings, relationships, places lived, family mental health history, substance abuse issues):

**In general, how would you describe your childhood?** Very happy---Mostly happy---Average---Unhappy---Very unhappy

Why?

**Who do you consider a source of support for you?**

**Medical History:** (Current health, allergies, current medications, medical hospitalizations, injuries)

**Psychiatric History:** (Hospitalizations, outpatient treatments, previous medications)

**Other agency/Legal involvement:** (Probation, arrests, current court issues, case management)

**What do you hope to achieve through treatment?**

**How optimistic are you that your concern(s) can be addressed?** Not at all---Mildly---Moderately---Highly