ADULT PERSONAL HISTORY

SOURCE: __Behavioral Health _____

Client name _____ Date of birth _____

Gender: ☐ Male ☐ Female ☐ Other Age _____

Hearing and/or vision difficulties: ☐ Hearing _____ ☐ Vision _____

Requires assistance to get around: ☐ None ☐ Yes _____

Form completed by (if other than client) _____

Referring provider _____

Primary reason(s) for seeking services:

☐ Addictive behaviors	☐ Attention/concentration	☐ Interpersonal problems	☐ Sexual concerns
☐ Alcohol/drugs	☐ Depression	☐ Learning problems	☐ Sleeping problems
☐ Anger management	☐ Eating disorder	☐ Memory	☐ Stress
☐ Anxiety	☐ Fear/phobias	☐ Mental confusion	☐ Other

_____

Family Information

Current relationship status _____

Past significant relationships _____

Who resides in your household with you *(name and age)*

_____

_____

Please list other significant people and/or support people in your life

_____

_____

Development

Are there special, unusual or traumatic circumstances that affected your development? ☐ Yes ☐ No
If yes, describe _____

Is there a history of abuse as a child? ☐ Yes ☐ No
If yes: ☐ Sexual ☐ Physical ☐ Verbal If yes, I was the: ☐ Victim ☐ Perpetrator ☐ Both

Other childhood issues: ☐ Neglect ☐ Inadequate nutrition, clothing, shelter, other _____

Any additional comments regarding childhood development? _____

Social Relationships

Significant social supports _____

Sexual issues? ☐ Yes ☐ No
If yes, describe _____

Culture/Ethnicity

To which cultural or ethnic group do you belong, if any _____

ADULT PERSONAL HISTORY

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Are there any specific concerns related to cultural or ethnic issues? ☐ Yes ☐ No
If yes, describe _____

Spiritual/Religious

How important are spiritual matters to you? ☐ Not ☐ Little ☐ Moderate ☐ Very
Are there any specific concerns related to spiritual or religious issues? _____

Self-Identity

How do you identify as far as race? _____ Gender identity? _____
Sexual orientation? _____ Any concerns related to these? _____

Legal

Current

Are you involved in any active cases? ☐ Yes ☐ No
If yes, check all that apply: ☐ Traffic ☐ Guardianship ☐ Divorce ☐ Parental custody ☐ Civil
☐ Other _____

Are you on probation or parole? ☐ Yes ☐ No
If yes, describe _____

Past

Traffic violations? ☐ Yes ☐ No DWI, DUI, etc.? ☐ Yes ☐ No
Criminal involvement? ☐ Yes ☐ No Civil involvement? ☐ Yes ☐ No
Other _____

Any past or current history of being a sexual perpetrator? ☐ Yes ☐ No
If yes, describe _____

Education

Are you currently enrolled in school? ☐ Yes ☐ No If yes, describe _____

Please describe your level of education using the following:

☐ High school grad/GED
☐ Vocational: Number of years _____ Graduated ☐ Yes ☐ No Major _____
☐ College: Number of years _____ Graduated ☐ Yes ☐ No Major _____
☐ Graduate: Number of years _____ Graduated ☐ Yes ☐ No Major _____

Employment

Are you currently employed? ☐ Yes ☐ No If yes, where _____

Please check which apply at present: ☐ FT ☐ PT ☐ Temp ☐ Laid-off ☐ Disabled ☐ Retired
☐ Social Security ☐ Student ☐ Other _____

ADULT PERSONAL HISTORY

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Military

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No Years of service _____

What was your military occupational specialty (MOS)? _____

Physical Issues

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

☐ Behavior ☐ Energy level ☐ Nervousness/tension ☐ Sleep patterns

☐ Eating patterns ☐ General disposition ☐ Physical activity level ☐ Weight

Describe changes in areas you checked above

_____

_____

Nutrition

Any significant weight loss/gain over the past three months? ☐ Yes ☐ No

Are there any specific concerns related to nutritional intake? ☐ Yes ☐ No

If yes, describe _____

If you use caffeine, how much do you consume daily, and what type _____

Family Mental Health and Substance Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol					☐	☐	☐	☐
Valium					☐	☐	☐	☐
Cocaine/crack					☐	☐	☐	☐
Heroin/opiates					☐	☐	☐	☐
Marijuana					☐	☐	☐	☐
PCP/LSD/Mescaline					☐	☐	☐	☐
Inhalants					☐	☐	☐	☐
Nicotine					☐	☐	☐	☐
Over-the-counter					☐	☐	☐	☐
Prescription drugs					☐	☐	☐	☐
Other					☐	☐	☐	☐

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Describe when and where you typically use substances and how often

_____

_____

ADULT PERSONAL HISTORY

SOURCE: __Behavioral Health _____

Has anyone in your family had a substance abuse issue in the past or present? ☐ Yes ☐ No
If yes, describe _____

Family Mental Health History

Please check to identify if these conditions are current or have occurred in relatives.

Condition	Mother	Father	Grandmother		Grandfather		Aunts/ uncles	Cousins	Siblings	Spouse/ partner	Children
			Maternal	Paternal	Maternal	Paternal					
Anxiety, panic attacks	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Manic symptoms/ bipolar disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric treatment/ hospitalizations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide attempts	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Suicide completion	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please check behaviors and symptoms that happen to you more often than you would like:

- ☐ Aggression
- ☐ Alcohol dependence
- ☐ Anger
- ☐ Antisocial behavior
- ☐ Anxiety
- ☐ Avoiding people
- ☐ Chest pain
- ☐ Computer addiction
- ☐ Depression
- ☐ Disorientation
- ☐ Distractibility
- ☐ Dizziness
- ☐ Drug dependence
- ☐ Eating disorder
- ☐ Elevated mood
- ☐ Fatigue
- ☐ Gambling
- ☐ Hallucinations
- ☐ Homicidal thoughts
- ☐ High blood pressure
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Irritability
- ☐ Judgement errors
- ☐ Loneliness
- ☐ Memory impairment
- ☐ Mood shift
- ☐ Panic attacks
- ☐ Phobias/fears
- ☐ Recurring thoughts
- ☐ Self-injurious thoughts/actions
- ☐ Sexual difficulties
- ☐ Sick often
- ☐ Sleeping problems
- ☐ Speech problems
- ☐ Suicidal thoughts
- ☐ Thoughts disorganized
- ☐ Trembling
- ☐ Withdrawing
- ☐ Worrying
- ☐ Other _____

Briefly discuss how the above symptoms impair your ability to function effectively

_____

_____

Prior Psychiatric or Psychological Services *(past and present)*

Have you ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No
If yes, when and where _____

Have you been in individual or group therapy in the past? ☐ Yes ☐ No
If yes, when and where _____

Do you currently or have you had suicidal thoughts or attempted suicide? ☐ Yes ☐ No
If yes, describe _____

ADULT PERSONAL HISTORY

SOURCE: __Behavioral Health _____

Do you or have you engaged in self-harm behaviors? ☐ Yes ☐ No
If yes, describe _____

Any additional information you believe would assist us in understanding your concern or problems?

_____
_____
_____

What are your goals for therapy and/or testing evaluation?

_____
_____
_____

Do you feel suicide at this time? ☐ Yes ☐ No
If yes, explain _____

Do you feel homicidal at this time? ☐ Yes ☐ No
If yes, explain _____

Signature _____ Date _____