On Deck Counseling, PLLC

Personal History—Adult (18+)

Client's name: _____ Gender: ___ F __ M Date: _____

Date of birth: _____ Age: _____ Form completed by: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone (home): _____ (work): _____ext: _____

Phone (cell): _____ (email): _____

Primary reason(s) for seeking services:

___ Addictive Behaviors ___ Depression ___ Sleeping Problems

___ Anger Management ___ Eating Disorders ___ Other _____

___ Alcohol/drugs ___ Fear/Phobias

___ Anxiety ___ Mental Confusion

___ Coping Skills ___ Sexual Concerns

Other mental health concerns (specify): _____

Marital Status (more than one answer may apply)

_ Single ___ Unmarried, living together Length of time: _____

_ Legally married Length of time: _____ ___ Separated Length of time: _____

___ Divorce in process Length of time _____ ___ Divorced Length of time: _____

___ Widowed Length of time _____ ___ Annulment Total number of marriages: ___

Assessment of current relationship (if applicable): ___ Great ___ Good ___Fair ___ Poor ___Awful

Development

Are there special, unusual, or traumatic circumstances that affected your development? __ No ___ Yes

Describe: _____

Has there been history of child abuse? __ No ___ Yes The abuse was as a: ___ Victim ___ Perpetrator

If Yes, which type(s)? _____Sexual _____ Physical _____Verbal _____ Emotional

Other childhood issues: ___ Neglect ___ Inadequate nutrition Other:_____

Special circumstances (e.g., raised by person other than parents) _____

_____

Comments about your childhood: _____

Legal History

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

Social Relationships

Check how you generally get along with other people: (check all that apply)

_____ Affectionate _____ Aggressive _____ Avoidant _____ Fight/argue often _____Follower

_____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn _____ Submissive

Other (specify): _____

Spiritual/Religious

How important to you are spiritual matters? _____ Not _____ Little _____ Moderate _____ Much

Would you like your spiritual/religious beliefs incorporated into the counseling? _____ Yes _____ No

Explain: _____

Education History

Fill in all that apply: Years of education: _____ Currently enrolled in school? _____ Yes _____ No

_____ 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: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Leisure/Recreation

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

_ AIDS
_ Abdominal pain
_ Abortion
_ Alcoholism
_ Allergies
_ Bed wetting
_ Cancer
_ Chest pain
_ Chronic pain
_ Diabetes
_ Dizziness
_ Drug abuse
_ Eating problems
_ Epilepsy
_ Fainting
_ Fatigue
_ Headaches
_ Hearing problems
_ Menstrual pain
_ Miscarriages
_ Nausea
_ Neurological disorders
_ Sexual problems
_ Sleeping problem
_ Thyroid problem
_ Other: _____

List any current health concerns: _____

List any recent health or physical changes: _____

Medications

Current prescriptions	Purpose	Side effects

Current over-the-counter meds	Purpose	Side effects

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

_____ Sleep patterns _____ Eating patterns _____ Behavior _____ Energy level _____Weight

_____ Physical activity level _____ General disposition (attitude) _____ Nervousness/tension

Describe changes in areas you checked above: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Most recent surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Chemical Use History (if applicable)

	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	_____		_____	_____	_____	_____	_____	_____
Barbiturates	_____		_____	_____	_____	_____	_____	_____
Valium/Librium	_____		_____	_____	_____	_____	_____	_____
Cocaine/Crack	_____		_____	_____	_____	_____	_____	_____
Heroin/Opiates	_____		_____	_____	_____	_____	_____	_____
Marijuana	_____		_____	_____	_____	_____	_____	_____
PCP/LSD/Mescaline	_____		_____	_____	_____	_____	_____	_____
Inhalants	_____		_____	_____	_____	_____	_____	_____
Caffeine	_____		_____	_____	_____	_____	_____	_____
Nicotine	_____		_____	_____	_____	_____	_____	_____
Over the counter	_____		_____	_____	_____	_____	_____	_____
Prescription drugs	_____		_____	_____	_____	_____	_____	_____
Other drugs	_____		_____	_____	_____	_____	_____	_____

Substance of preference

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

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends : _____

Reason(s) for use: ___ Addicted ___ Build Confidence ___ Escape ___ Taste ___ Self-medication ___ Socialization ___ Other (specify): _____

How do you believe your substance use affects your life?

Who or what has helped you in stopping or limiting your use?

Have drugs or alcohol created a problem for your job? __ Yes ___ No Describe: _____

_____

Counseling or Prior Treatment History (if applicable)

	No	Yes	When	Where	Your Reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups	___	___	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

_ Aggression
_ Anger
_Antisocial behavior
_Anxiety
_ Avoiding people
_ Chest pain
_Cyber addiction
_ Depression
_ Disorientation
_ Distractibility
___ Dizziness
___ Drug dependence
___ Eating disorder
___ Elevated mood
___ Fatigue
___ Gambling
___ Hallucinations
___ Heart palpitations
___ Hopelessness
___ Impulsivity
___ Irritability
___ Judgment errors
___ Loneliness
___Memory impairment
___ Mood shifts
___ Panic attacks
___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Suicidal thoughts
___ Trembling
___ Withdrawing
___ Worrying
___ Other: _____
_____
_____
_____

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

_____

_____

_____

_____

Any additional information that would assist me in understanding your concerns or problems:

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

Do you feel suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

_____

Do Not Complete This Section

Therapist's signature/credentials: _____ Date: _____

Comments: _____

_____

_____

Physical exam: ___ Requested __ Not requested