Claire Ellison Counseling

PERSONAL HISTORY FORM

I. PRESENTING PROBLEMS

What prompted you to seek treatment? _____
_____
_____
_____
_____
How long has this been a problem for you? _____

How would you rate the severity of the problem today? __Mild __Moderate __Serious __Severe

How would you rate the severity of the problem 1 month ago? __Mild __Moderate __Serious __Severe

What specific symptoms/problems do you think are relevant to your treatment? Please check all that apply.

__ Aggressive behaviors
__ Angry outbursts
__ Crying easily
__ Trouble concentrating
__ Fatigue or loss of energy
__ Depressed mood
__ Feelings of worthlessness
__ Thoughts of hurting yourself or others
__ Nightmares
__ Sleep disturbances
__ Relationship problems (peers, family)
__ Financial stress
__ Academic problems
__ Odd behaviors or thoughts
__ Taking alcohol/drugs
__ Difficulty following directions
__ Abusive relationships
__ Recent weight change
__ Fears/phobias
__ Coping problems
__ Legal problems
__ Social withdrawal
__ Distrust
__ Bonding/Attachment issues with others
__ Restlessness
__ Recent traumatic events
__ Unresolved childhood issues
__ Adoption issues
__ Increased illnesses or medical problems
__ Marital problems
__ Sexual identity issues
__ Defiant behaviors
__ Grief or loss issues
__ Parenting problems

II. BIOPSYCHOSOCIAL

FAMILY INFORMATION

Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

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Significant Others (Brothers, Sisters, Step-relatives, Half-relatives, Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No

Marital Status (more than one answer may apply)
_____ Single _____Married _____Divorced _____Separated

Assessment of Current Relationship (if applicable) ___ Good ___ Fair ___Poor
Please explain: _____
_____

Parental Information
_____ Parents legally married
_____ Parents have ever been separated
_____ Parents ever divorced
_____ Mother remarried: Number of times _____
_____ Father remarried: Number of times _____

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)
_____
_____
_____

Strengths/support _____
Stressors/problems _____

DEVELOPMENT

Have you ever been abused as a child or an adult? _____ No _____Yes
If yes, which types of abuse? _____ Sexual _____ Physical _____ Verbal _____ Perpetrator _____Victim
If yes, was the abuse ever reported? _____ No _____Yes

Other childhood issues: ___ Neglect ___ Inadequate Nutrition ___ Medical Complications
Comments regarding childhood experiences: _____
_____
_____
_____
_____

SOCIAL RELATIONSHIPS

Check how you generally interact with friends and family members: (check all that apply)
_____ Lovingly _____ Fight/Argue _____ Get picked on _____ Try to avoid them
Other (specify) _____

How would you describe your personality? (check all that apply)
_____ Follower _____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn

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Do you have a best friend now? _____ No _____ Yes In the past? _____ No _____ Yes

Strengths/support _____
Stressors/problems _____

CULTURAL / ETHNIC

From which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? _____ No _____ Yes (describe) _____
_____
Other cultural / ethnic information: _____
_____
Strengths/support _____
Stressors/problems _____

SPIRITUAL / RELIGIOUS

How important to you are spiritual matters? _____ Not _____ Little _____ Moderate _____ Much
Are you affiliated with a spiritual or religious group? _____
Were you raised within a spiritual or religious group? _____ No _____ Yes (describe) _____
Strengths/support _____
Stressors/problems _____

LEGAL

List all arrests (charges), dates of arrests, and the outcomes
_____
_____
_____
Please describe any past or present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling, etc.) _____

Strengths/support _____
Stressors/problems _____

EDUCATIONAL

(CHILD/TEEN)
What grade are you in? _____ What school do you attend? _____
Academic Grades: *above average, average, below average, inconsistent*
Are you in Special Education Classes? _____ No _____ Yes (describe) _____
Have you ever failed a grade? _____ No _____ Yes Which one(s)? _____
How many schools have you attended? _____

(ADULT)
Graduated from High School/GED? _____ No _____ Yes Year Completed? _____
College: _____ Major: _____ Year Completed? _____
Are you satisfied with your level of education? Explain: _____
_____
Strengths/support _____
Stressors/problems _____

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EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left the Job	How often miss work?

Strengths/support _____
Stressors/problems _____

MILITARY

Military Experience? _____ No _____ Yes Combat History? _____ No _____ Yes
Branch _____ Discharge Date _____ Date Drafted _____ Type of Discharge _____ Date Enlisted _____ Rank at Discharge _____

Strengths/support _____
Stressors/problems _____

LEISURE / RECREATIONAL

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

_____
_____

Strengths/support _____
Stressors/problems _____

MEDICAL / PHYSICAL HEALTH

_____ Active Medical Problems ____ Past Hospitalizations _____ Current Medications
_____ Major Medical Illness _____ Other Medical Problems (describe) _____
If "Yes," describe: _____
Do you currently have any medical problems that are not being treated by a doctor, but should be?
_____ No _____ Yes (describe) _____

List any family history of medical problems: _____
_____

Please check if there have been any recent changes in the following:
_____ Sleep patterns _____ Eating patterns _____ Behavior _____ Energy level
_____ Physical activity level _____ General disposition _____ Weight _____ Nervousness
Describe changes marked above: _____
_____
_____

CHEMICAL USE HISTORY

Have you ever used any illegal drugs? _____ No _____ Yes (describe) _____
_____

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Do you drink alcohol? _____ No _____ Yes (describe frequency and amount) _____
_____

Have any of your family members or significant relationships had a problem with drugs or alcohol?
_____ No _____ Yes (describe who and circumstances) _____
_____

Describe how drugs or alcohol have affected your life: _____
_____

COUNSELING / PRIOR TREATMENT HISTORY

Have you ever participated in any counseling/therapy services? _____ No _____ Yes (describe when/where)
_____
_____
Are you currently seeing another therapist? _____ No _____ Yes If so, who? _____
Have any of your family members or significant relationships been involved in counseling or treatment?
_____ No _____ Yes (describe) _____
_____
Have you ever been hospitalized for drugs/alcohol/psychiatric care? _____ No _____ Yes (when/where)
_____
_____
Have you ever been involved in any self-help groups (AA, NA, Al-Anon, etc.)? _____ No _____ Yes
Which ones? _____
Have you ever attempted suicide or had suicidal thoughts? _____ No _____ Yes (describe)
_____
_____
Are you feeling suicidal now? _____ No _____ Yes

CLIENT OPINION ABOUT STRENGTHS AND NEEDS

What do you see as your/your family strengths?
_____
_____
_____
_____
_____
_____

Is there any other information about you that you think is relevant for your treatment planning?
_____
_____
_____
_____
_____
_____

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Please list at least one goal you would like to reach during the course of your treatment.

_____
_____
_____
_____
_____
_____

_____ _____

SIGNATURE OF PERSON COMPLETING THIS FORM DATE

_____

RELATIONSHIP TO THE CLIENT

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