northwinds
counseling services, p.a.

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Personal History Form - Adult

Name: _____Age: _____ D.O.B. _____ Gender: M F

Primary reason(s) for seeking services:

____ Depression ____ Anxiety ____ Alcohol/drugs ____ Anger management
____ Coping ____ Fear/phobias ____ Behavior problems _____ Martial issues/conflict
Other _____

Please circle behaviors and symptoms that are problematic:

Aggression	Worrying	Hallucinations	Attention Deficit
Anxiety	Heart Palpitations	People avoidant	Trouble concentrating
Depression	Recurring thoughts	Disorientation	Sexual problems
Alcohol problems	Irritability	Cyber addiction	Antisocial behavior
Fatigue/Tired	Impulsivity	Speech problems	Sleep problems
Panic attacks	Distractibility	Gambling problems	Fears/phobias
Anger	Chest pain	Sick often	Self injury/behavior
Hopelessness	Loneliness	Alcohol/Drug issues	Memory problems
Suicidal thoughts	Mood swings	Eating issues	Withdrawing/isolating

Do you feel suicidal at this time? Yes or No Do you have a plan if you are suicidal? Yes or No
Briefly describe how the symptoms impair your ability to function effectively. _____

_____
_____

Please include any additional information that would assist us in understanding your concerns and problems?
_____
_____
_____

Have you recently experienced any that follow?

Recent death or birth in the family	Accident, fire, disaster	Separation or divorce
Job loss or change	Arrest or DUI	Major Financial problems
Change in living arrangements	Physical/emotional abuse	Sexual abuse or assault
Thoughts/acts of violence to others	Thoughts/acts of hurting self	Custody issues
Pregnancy, miscarriage, abortion	Diagnosis of major illness	Significant relationship discord

Parental Information (circle)

Parents legally married Parents never married Parents divorced at what age (yours) _____
Special circumstances (e.g., raised by person other than parents, information about spouse/kids not living with you etc.): _____

Marital status (circle):

Single Years living together ____ Years legally married ____ Years widowed _____
Divorcing Months separated _____ Years divorced _____ Number of marriages _____
Assessment of current relationship: good fair poor abusive

Developmental history

Has there been a history of child abuse? Yes or No If yes, which type: ___ Sexual ___ Physical ___Verbal
Other childhood issues: ___Neglect _____Exposure to trauma _____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain _____

Social Relationships

Circle how you generally get along with other people:

Affectionate	Aggressive	Avoidant	fight/argue often	Follower
Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

What is your sexual orientation? _____

Have you experienced any Sexual dysfunctions? Yes or No

Spiritual/Religious

Are you connected with a spiritual or religious group? Please explain_____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Are you involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges _____
Are you currently on probation or parole? Yes or No
Have you been accusations of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education: Currently enrolled in school High school grad/GED Vocational school
Some College College Graduate Masters or Doctorate
Any learning disabilities: Yes or No If yes, please explain _____

Employment: Current employer _____

Fulltime	Part time	Temp	Laid-off	Disabled	Retired	Social Security
Job satisfaction:		poor	good	fair	great	

Military experience? Yes or No Combat experience? Yes or No
Where: _____ Branch: _____ Type of discharge _____ Service length _____

Leisure/Recreational

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 sports, etc.)

_____

_____

Medical/Physical Health

Primary care Doctor _____ phone _____
List any current health conditions you have and any recent health changes: _____
Are you currently using any prescribed medications: _____

Please circle if there have been any changes in the following:

Sleep patterns Eating patterns Behavior Energy level Physical activity level

General disposition Weight Nervousness/tension

Others: _____

Chemical use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Use in last 48 hours	Used in last 30 days
					yes	**yes**
Alcohol	_____	_____	_____	_____	**yes**	**yes**
Cocaine/Crack	_____	_____	_____	_____	**yes**	**yes**
Meth	_____	_____	_____	_____	**yes**	**yes**
Marijuana	_____	_____	_____	_____	**yes**	**yes**
Valium/Librium	_____	_____	_____	_____	**yes**	**yes**
Heroin/Opiates	_____	_____	_____	_____	**yes**	**yes**
PCP/LSD/Mescaline	_____	_____	_____	_____	**yes**	**yes**
Inhalants	_____	_____	_____	_____	**yes**	**yes**
Caffeine	_____	_____	_____	_____	**yes**	**yes**
Nicotine	_____	_____	_____	_____	**yes**	**yes**
Pain killers	_____	_____	_____	_____	**yes**	**yes**

Drug of choice

How does your use affect your life? _____
Has anyone expressed concern about your use? Yes or No
Are you concerned about your use? Yes or No
Are there presently or past history of a family member having problems with drugs or alcohol? Yes or No
Consequences experienced because of your use? Legal, relational, physical, mental, job, financial
Please explain: _____

_____

Counseling Prior treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____

Hospitalizations _____ _____ _____ _____
Is there a family history of mental illness or substance abuse problems? _____

Please list treatment goals wished to accomplish.
_____
_____

GENOGRAM

	NAME	AGE	YEARS Deceased	Quality of relationships now	Living w/ you		
				Good/Fair/ Poor			
Father							
Mother							
Step-parent							
Step-parent							
Sibling							
Grandparent							
Other							

Thank you for your time completing the questionnaire.