

ADULT PERSONAL HISTORY FORM

Client's Name: _____ Birthdate: _____

Reason for seeking treatment: _____

Emergency contact: _____

Name

Phone

FAMILY INFORMATION

	Name	Sex	Age	Lives with you (Yes/No)	Indicate if deceased
Spouse/Significant other					
Children					
Mother					
Father					
Brothers/Sisters					

PARENTAL INFORMATION

Children not listed or not living with you: _____

Special Circumstances (eg. raised by someone other than a parent, adoption, etc.) _____

ISSUES THAT AFFECTED YOUR DEVELOPMENT (physical or sexual abuse, nutrition, illness, neglect, etc.)

ADULT MARITAL HISTORY

Your Current Marital Status: Single Married Divorced Separated Widowed Other

Your first marriage _____
Age / Date / No. of Children / If divorced, give date

Your second marriage _____
Age / Date / No. of Children / If divorced, give date

Check the best description of your relationship with your present significant other:

- Excellent Good Fair Poor

Social Information

Social time is usually spent: Alone Immediate family Peers

Please describe: _____

Do you isolate yourself from other people? _____

Cultural/Ethnic Background

What is the ethnic group of your parents? (Hispanic, African American, Asian, etc.)

Do you identify with this same group, or another? _____

Spiritual/Religious Background

Were you raised in a home that practiced a religion? Yes No

If yes, which religion: _____

Do you consider yourself a religious person? Yes No

Do you practice a formal religion now? Yes No

If yes, which religion? _____ Do you consider yourself a spiritual person? Yes No

ADVANCED COUNSELING SERVICES, P.C.

Legal Information

Have you ever been involved with the police or the courts? Yes No

If yes, please specify:

<u>Charge</u>	<u>Date</u>	<u>Results</u>	<u>Was this related to Alcohol or other drug use</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you presently on probation or parole? Yes No

If yes, please explain: _____

Military Service

Have you ever served in the armed forces? Yes No

Branch: _____ Enlistment date: _____ Discharge date: _____

Rank: _____ Combat experience: Yes No

If yes, where and when? _____

Education

Highest grade completed? _____ High school diploma G.E.D. Attend night school

Some college College Degree _____ *Major* _____ Graduate Degree _____ *Field* _____

List any vocational training you have had: _____

Are you satisfied with your education? Yes No If No, why not? _____

Leisure/Recreational

List your hobbies, leisure time activities, interests: _____

Has your level of activity changed? Yes No If yes, explain how: _____

Employment/Vocational Information

Employers (most recent first)	Dates	Job Descriptions

Are you currently employed outside the home? Yes No Full time Part time

Special circumstances (*laid off, medical leave, suspended, retired, etc.*): _____

Total family income: _____ Do you currently have financial problems? Yes No If yes, please explain: _____

Counseling/Prior Treatment History?

Have you had psychotherapy/counseling before? Yes No If yes, where:

Name of Center	Type of Service (Outpatient/Inpatient/Day Treatment)	Dates	Drug of Alcohol Treatment (Yes/No)

Do you attend "A.A." or "N.A." Yes No How often? _____

Do you attend any other support groups? Yes No

If yes, describe: _____

Have you ever experienced thoughts of harming yourself or another person? Yes No

If yes, please explain: _____

Have you ever attempted to harm yourself or another person? Yes No

If yes, please explain: _____

Do you have a history of any suicidal attempts? Yes No If yes, please describe: _____

Chemical Use History

Substance	Age at first use	Age at regular use	Age at last use	Amount used in last 48 hrs.	Amount used in last 30 days
Alcohol					
Barbiturates					
Valium/Librium					
Cocaine/Crack method of use: _____					
Heroin/Opiates method of use: _____					
Marijuana					
PCP/LSD/Mesc.					
Inhalants					
Caffeine					
Nicotine					
Over-Counter					
Rx Drugs					
Other Drugs					

Substance of Preference

1. _____ 2. _____

Describe when and where you typically use: _____

Describe any changes in your use patterns: _____

Do you use to build up your confidence? Yes No

What is your perception of your use? _____

Describe who or what has helped you: _____

Who in your family (present/past) has had a problem with drugs or alcohol? _____

Have you had withdrawal symptoms when trying to stop drinking? Yes No

If yes, describe: _____

Does your temperament change when you drink? (Describe): _____

Do you have an increased tolerance with drugs or alcohol? (Describe) _____

Have you experienced blackouts? Yes No If yes, describe: _____

Have you ever overdosed? Yes No If yes, describe: _____

Physical Health

Your current physician: _____

Name

Address

Phone Number

Date last seen by your physician: _____

Reasons for seeing your physician: _____

Current Medications: _____

Over the counter medications: _____

List any surgeries, hospitalizations, or past treatment procedures: _____

Are you allergic to any medication or drugs? Yes No If yes, what medications are you allergic to?

Family history of medical and emotional problems: _____

Client Signature: _____ **Date:** _____

STAFF USE ONLY

Therapist Signature/Credentials

Date

Based on the information provided above a physical exam: Is Required Is Not Required

M.D./D.O. Comments _____

Physician Signature

Date