

Personal History Questionnaire

This questionnaire is intended to help your clinician review general information quickly so that your session with her can focus on the concerns, which led to your scheduling this appointment. Feel free to leave blank any questions which do not apply or which you prefer not to answer in this format. I will follow-up with you for additional information pertaining to some items on this form. This form will be held in confidence as part of your patient record in this office.

NAME: _____ BIRTHDATE: _____ DATE: _____

Please Summarize Your Reasons for Seeking Services at This Time

EDUCATIONAL HISTORY

What is your last grade completed or degrees earned? _____

During school do or did you receive any: ___ Special education? ___ Tutoring? ___ Alternative Schooling?

Have you ever served in the military? ___ Yes ___ No If yes, please answer the following:

Dates of service: _____ Type of Discharge: _____ Combat experience? _____

VOCATIONAL HISTORY (if applies)

What is your current occupation? _____

How long have you been employed in your present position? _____

Since becoming an adult, how many different jobs have you held? _____

Have you had any periods of unemployment, which lasted four months or longer? ___ Yes ___ No

If yes, please describe circumstances briefly: _____

Have you made any career changes? ___ Yes ___ No

If yes, what was/were your previous occupations? _____

Are you satisfied with your current job? ___ Yes ___ No

Have there been any major changes in your current work situation during the past year? ___ Yes ___ No

If yes, please describe: _____

MEDICAL HISTORY

Please list all medications you are currently taking, including dosages if you know them:

Medication	Dosage	Prescribed By
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had major surgery? _____ Yes _____ No

Have you ever had a head injury, which resulted in loss of consciousness or which may have been associated with a concussion or with problems in thinking, emotion or behavior? _____ Yes _____ No

Have you ever had an extremely high fever (greater than 103° F)? _____ Yes _____ No

Have you ever fainted or had a seizure? _____ Yes _____ No

Do you have any medication allergies or sensitivities? _____ Yes _____ No

If yes, please specify: _____

Do you have any food or seasonal allergies or sensitivities? _____ Yes _____ No

If yes, please specify: _____

Do you regularly engage in physical exercise? _____ Yes _____ No

Do you, or have you in the past, regularly used cigarettes _____ Yes _____ No

Please list any other medical conditions or concerns: _____

PSYCHOLOGICAL TREATMENT HISTORY

Have you every taken medication for psychological/psychiatric reasons? _____ Yes _____ No

If yes, please indicate when, and what conditions/problems: _____

Have you received counseling or psychotherapy previously? _____ Yes _____ No

If yes, please indicate when, and by whom: _____

Have you ever been hospitalized for psychological/psychiatric reasons? _____ Yes _____ No

Has anyone in your family (parents, grandparents, siblings, other relative) been diagnosed and/or treated for psychological/psychiatric condition(s)? _____ Yes _____ No

ALCOHOL/DRUG HISTORY (if applicable)

If you drink alcohol, please describe the type of alcoholic beverages, the amounts, and the frequency:

If you have used, or currently use any street drugs, please describe which ones and your pattern(s) of use:

Have you ever tried to cut down on your use of alcohol or drugs? _____ Yes _____ No

Has anyone gotten angry with you because of your alcohol or drug use? _____ Yes _____ No

Have you ever felt guilty or worried about your use of alcohol or drugs? _____ Yes _____ No

Have you ever received outpatient alcohol / drug treatment or detoxification services? _____ Yes _____ No

Have you ever received inpatient alcohol / drug treatment or detoxification services? _____ Yes _____ No

Has anyone in your family had a problem with alcohol or drugs? _____ Yes _____ No

LEGAL HISTORY

Please check all legal actions or proceedings you have been a part of:

_____ Arrests/assaults _____ Arrests/other _____ DUI(how many?_____)

_____ Restraining/protective order(s) _____ Child Protective Services _____ Divorce/custody

_____ Disability claim(s) Other (describe) _____

PERSONAL INFORMATION

Have you experienced a loss (death, divorce, or significant situational losses) with the past 24 months?

_____ Yes _____ No

Did you experience any losses (as described above) during childhood, adolescence (ages 13-25)?

_____ Yes _____ No

If yes, please indicate whom, and your age at the time of loss: _____

Have you relocated or changed jobs within the past 24 months? _____ Yes _____ No

How many siblings do you have, and what is your birth order among them? _____

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Were you adopted or separated from your birth parents during childhood? _____ Yes _____ No

Were your parents divorced (if yes, please indicate your age at the time of their separation?) _____ Yes _____ No _____

Please indicate your parent's current ages, or their ages at the time of their deaths: _____

Has religion or spirituality played an important role in your life? _____ Yes _____ No

Do you own or have access to firearms? _____ Yes _____ No

Describe your developmental history (Were there any pregnancy complications? Did your mom use drugs or alcohol while pregnant? Were there any complications w/your birth and delivery? Anything else you'd like to add about your development)

COUPLES COUNSELING

If you are seeking couples counseling:

How long have you been together? _____

How long were you dating before moving in together _____ or getting married? _____

With 1 being 'not very' and 10 'very much so', how satisfied are you with the following aspects of your relationship:

Emotional connection?

Physical intimacy?

Communication?

Parenting?

Trust?

Finances?

In-Laws / extended family?

Thank you for taking time to complete this questionnaire. Its purpose is to gather general information – I will follow up in more detail as appropriate. Please use this space below to provide any additional information that you think would be important for me to know. Also, please feel free to use the space below to describe your current goals for the services I will be providing.

Your signature: _____

Reviewed by: _____ Date: _____

Clinician's signature