Life's Journey Counseling and Community Services
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Personal History—Adult (18+)

Client's name:____ **Date:**______________

Gender:__ **F** ___ **M** **Date of birth:**________**Age:** ____________________

Form completed by (if someone other than client): ____

Address:_________________________**City:**________________**State:**_____ **Zip:** ___________

Phone (home):____________________**(work):**_______________________**ext:** _______________

Email address:____

Emergency Contact:____**Phone:**__________________

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ____ Anxiety ____ Coping ____ Depression

___ Eating disorder ___ Fear/phobias ____ Mental confusion ____ Sexual concerns

___ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs

___ Other mental health concerns (specify): ____

Family Information

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

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No

Marital Status (more than one answer may apply)

__ Single

___ Divorce in process
Length of time: ___________

____ Unmarried, living together
Length of time: ____________

__ Legally married
Length of time: ____________

___ Separated
Length of time: ___________

___ Divorced
Length of time: ____________

__ Widowed
Length of time: ____________

___ Annulment
Length of time: ___________

Total number of marriages: _

Assessment of current relationship (if applicable):_Good ____Fair_____Poor

Parental Information

__ Parents legally married

____Mother remarried: Number of times: ______

__ Parents have ever been separated

____Father remarried: Number of times: ______

__ Parents ever divorced

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

Development

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

If Yes, please describe: ____

Has there been history of child abuse?___ Yes ___ No

If Yes, which type(s)?____Sexual ____Physical ____Verbal

If Yes, the abuse was as a:____Victim ____Perpetrator

Other childhood issues: Neglect Inadequate nutrition_ Other (please specify): _______________

Comments re: childhood development: ____

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): ____

Sexual orientation:________________Comments: ____

Sexual dysfunctions? ___ Yes ___ No

If Yes, describe: ____

Any current or history of being as sexual perpetrator? __ Yes_ No

If Yes, describe: ____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? ________________________________

Are you experiencing any problems due to cultural or ethnic issues? ____Yes ____ No

If Yes, describe: ____

Other cultural/ethnic information: ____

Spiritual/Religious

How important to you are spiritual matters?__Not ___ Little____Moderate_____Much

Are you affiliated with a spiritual or religious group? ___Yes ___No

If Yes, describe: ____________________

Were you raised within a spiritual or religious group? ____Yes ___ No

If Yes, describe: ____________________

Would you like your spiritual/religious beliefs incorporated into the counseling?____Yes____No

If Yes, describe: ____________________

Legal

Current Status

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

If Yes, please describe and indicate the court and hearing/trial dates and charges: ____________________

Are you presently on probation or parole? ___ Yes ____No

If Yes, please describe: ____________________

Past History

Traffic violations: ____Yes ___ No

DWI, DUI, etc.: ___Yes ___ No

Criminal involvement:____Yes ___ No

Civil involvement:___Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

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): ____________________

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____FT_____PT __ Temp____Laid-off______Disabled_____Retired

__ Social Security _ Student ____Other (describe): ______________________________

Military

Military experience? ___ Yes ___ No Combat experience?___ Yes ___ No

Where:____

Branch:____________________________Discharge date: ______________________

Date drafted:________________________Type of discharge: __________________

Date enlisted:_______________________Rank at discharge: __________________

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, etc.)

Activity	How often now?	How often in the past?

Medical/Physical Health

___ AIDS	____ Dizziness	____ Nose bleeds
___ Alcoholism	____ Drug abuse	____ Pneumonia
___ Abdominal pain	____ Epilepsy	____ Rheumatic Fever
___ Abortion	____ Ear infections	____ Sexually transmitted diseases
___ Allergies	____ Eating problems	____ Sleeping disorders
___ Anemia	____ Fainting	____ Sore throat
___ Appendicitis	____ Fatigue	____ Scarlet Fever
___ Arthritis	____ Frequent urination	____ Sinusitis
___ Asthma	____ Headaches	____ Smallpox
___ Bronchitis	____ Hearing problems	____ Stroke
___ Bed wetting	____ Hepatitis	____ Sexual problems
___ Cancer	____ High blood pressure	____ Tonsillitis
___ Chest pain	____ Kidney problems	____ Tuberculosis
___ Chronic pain	____ Measles	____ Toothache
___ Colds/Coughs	____ Mononucleosis	____ Thyroid problems
___ Constipation	____ Mumps	____ Vision problems
___ Chicken Pox	____ Menstrual pain	____ Vomiting
___ Dental problems	____ Miscarriages	____ Whooping cough
___ Diabetes	____ Neurological disorders	____ Other (describe): __________
___ Diarrhea	____ Nausea	______________________

List any current health concerns: ____

List any recent health or physical changes: _____________________________________

____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____/ week	______________________	___No __ Low____Med ____High
Lunch	____/ week	______________________	___No __ Low ____Med ____High
Dinner	____/ week	______________________	___No __ Low ____Med ____High
Snacks	____/ week	______________________	___No __ Low ___ Med ____High

Comments: ____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs?___Yes ___ No

If Yes, describe: ____

	Date	Reason	Results
Last physical exam	________	______________________	______________________
Last doctor's visit	________	______________________	______________________
Last dental exam	________	______________________	______________________
Most recent surgery	________	______________________	______________________
Other surgery	________	______________________	______________________
Upcoming surgery	________	______________________	______________________

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/tension

Describe changes in areas in which you checked above: ______________________________

Chemical Use History

	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.____________________________________ 3. ____________________________________

2.____________________________________ 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 (include their perceptions of your use): _____

Reason(s) for use:

___ Addicted ____ Build confidence ____ Escape ____ Self-medication

___ Socialization ____ Taste ____ Other (specify): ____________________

How do you believe your substance use affects your life? ______________________________

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

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

____Yes ____ No If Yes, describe: ______________________________

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____No

If Yes, describe: ______________________________

Have you had adverse reactions or overdose to drugs or alcohol? (describe):____________________

Does your body temperature change when you drink?___ Yes ____ No

If Yes, describe: ______________________________

Have drugs or alcohol created a problem for your job?____ Yes ___No

If Yes, describe: ______________________________

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	________	________	________
Suicidal thoughts/attempts	____	____	________	________	________
Drug/alcohol treatment	____	____	________	________	________
Hospitalizations	____	____	________	________	________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	________	________	________

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	________	________	________
Suicidal thoughts/attempts	____	____	________	________	________
Drug/alcohol treatment	____	____	________	________	________
Hospitalizations	____	____	________	________	________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	____	________	________	________

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

- ___ Aggression
- ___ Alcohol dependence
- ___ 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
- ____ High blood pressure
- ____ Hopelessness
- ____ Impulsivity
- ____ Irritability
- ____ Judgment errors
- ____ Loneliness
- ____ Memory impairment
- ____ Mood shifts
- ____ Panic attacks
- ____ Phobias/fears
- ____ Recurring thoughts
- ____ Sexual addiction
- ____ Sexual difficulties
- ____ Sick often
- ____ Sleeping problems
- ____ Speech problems
- ____ Suicidal thoughts
- ____ Thoughts disorganized
- ____ Trembling
- ____ Withdrawing
- ____ Worrying
- ____ Other (specify): __________ ______________________

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

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

What are your goals for therapy?

Do you feel suicidal at this time? ___Yes ___No
If Yes, explain:

For Staff Use

Therapist's signature/credentials:________________________________ Date:_____/____/_____

Supervisor's comments: ____

___________________________________ Physical exam:_ Required____Not required

Supervisor's signature/credentials:_______________________________ Date:_____/____/_____
(Certifies case assignment, level of care and need for exam)