

# Personal History

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If questions do not apply to you, leave them blank.

## Identifying Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Partner's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Street & Number

\_\_\_\_\_

City

State

Zip

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Best time to reach you and at which phone number? \_\_\_\_\_

Where is it ok to leave messages for you?  Home  Business  Cell  Email

Others living in the home: \_\_\_\_\_, \_\_\_\_\_  
Name, birthdate, relationship to client Name, birthdate, relationship to client

\_\_\_\_\_, \_\_\_\_\_  
Name, birthdate, relationship to client Name, birthdate, relationship to client

Years of education or degree: Self \_\_\_\_\_ Partner: \_\_\_\_\_

Occupation: Self: \_\_\_\_\_ Partner: \_\_\_\_\_

Employer: Self: \_\_\_\_\_ Partner: \_\_\_\_\_

Social Security Number: Self: \_\_\_\_\_ Partner: \_\_\_\_\_

Present Marital Status: \_\_\_\_\_

Emergency contact: \_\_\_\_\_

Telephone: \_\_\_\_\_

Who referred you or how did you hear about my services?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information:**

Client's Name: \_\_\_\_\_ Client's Date of Birth: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Address of Insured Person: : \_\_\_\_\_

Street & Number

\_\_\_\_\_

City

State

Zip

Relationship of Client to Insured Person: \_\_\_\_\_

Employer of Insured Person: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Specific Insurance Plan Name: \_\_\_\_\_

Phone Number for Claims: \_\_\_\_\_

Insurance Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Are you seeking help due to:

Employment? Yes or No \_\_\_ Auto Accident Yes or No \_\_\_ Other Accident? Yes or No \_\_\_

Secondary Insurance: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Secondary Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Secondary Company Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Secondary Identification Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

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**For Office Use**

Date of Service: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

CPT Code: \_\_\_\_\_

Prior Balance and Description of Arrangements Made: \_\_\_\_\_

\_\_\_\_\_

Payment Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Counseling History

What are your main reasons for this visit?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you receiving counseling services from anyone else at present?: Yes \_\_\_ No \_\_\_  
If Yes, please briefly describe:

\_\_\_\_\_  
\_\_\_\_\_

Have you received counseling in the past?: Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please briefly describe your experience and the results:

\_\_\_\_\_  
\_\_\_\_\_

## Medical History:

Name and address of your primary physician:

Physician's name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

List any major illnesses and/or operations you have had: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, pain, etc):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was your most recent complete physical exam?: \_\_\_\_\_

Results of physical exam: \_\_\_\_\_  
\_\_\_\_\_

Have you gained/lost over ten pounds in the past year?: \_\_Yes \_\_No, \_\_gained \_\_lost

If Yes, was the gain/loss on purpose?: \_\_Yes \_\_No

Describe your appetite (during the past week):

\_\_\_\_\_ poor appetite                      \_\_\_\_\_ average appetite                      \_\_\_\_\_ large appetite

What medications (and dosages) are you taking at present, and for what purpose?:

Medication

Purpose

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Symptoms

Check any Problems that Describe Your Childhood

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Violence         | <input type="checkbox"/> ADHD (Attention Deficit) | <input type="checkbox"/> Bedwetting                      |
| <input type="checkbox"/> Theft            | <input type="checkbox"/> Trauma _____             | <input type="checkbox"/> Learning Disabilities           |
| <input type="checkbox"/> Persistent Lying | <input type="checkbox"/> Cruelty to Animals       | <input type="checkbox"/> Fetal Alcohol Syndrome          |
| <input type="checkbox"/> Truancy          | <input type="checkbox"/> Vandalism                | <input type="checkbox"/> Bullying                        |
| <input type="checkbox"/> Fire Starting    | <input type="checkbox"/> Classroom Disruption     | <input type="checkbox"/> Being Bullied                   |
| <input type="checkbox"/> Sexual Behavior  | <input type="checkbox"/> Substance Abuse          | <input type="checkbox"/> Suspended, Expelled from School |

**Check the behaviors and symptoms that occur to you more often than you would like them to**

- |                           |                          |                             |
|---------------------------|--------------------------|-----------------------------|
| _____ aggression          | _____ fatigue            | _____ sexual difficulties   |
| _____ alcohol dependence  | _____ hallucinations     | _____ sick often            |
| _____ anger               | _____ heart palpitations | _____ sleeping problems     |
| _____ antisocial behavior | _____ hopelessness       | _____ speech problems       |
| _____ anxiety             | _____ impulsivity        | _____ suicidal thoughts     |
| _____ avoiding people     | _____ insomnia           | _____ thoughts disorganized |
| _____ chest pain          | _____ irritability       | _____ trembling             |
| _____ depression          | _____ judgment errors    | _____ withdrawing           |
| _____ disorientation      | _____ loneliness         | _____ worrying              |
| _____ distractibility     | _____ memory impairment  | _____ other (specify)       |
| _____ dizziness           | _____ mood shifts        | _____                       |
| _____ drug dependence     | _____ panic attacks      | _____                       |
| _____ eating disorder     | _____ phobias/fears      | _____                       |
| _____ elevated mood       | _____ recurring thoughts | _____                       |

## Substance Use:

Name of Drug	Most Frequent Use (How much and when)	Date of Last Use	Age at the Time of First Use
Alcohol			
Marijuana			
Amphetamine			
Cocaine			
Other:			
Other:			

Have you been, or are you in treatment for drug or alcohol problems? \_\_\_\_\_

Where, when:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

