PERSONAL HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Today's Date: _____

To help your therapist understand you to assist you – please fill out the following sections carefully and fully. If the client is a child, please answer on their behalf.

1. In your own words, why are you here? _____
_____

_____

_____

I agree to allow Mental Health Clinic personnel to telephone me at my home, work, or other settings. This is for reminder of session calls, missed appointment calls or other.
[ ] Yes [ ] No

Please complete the following:

2. EDUCATIONAL BACKGROUND:

Any special needs or classes in school? _____

_____

What is your desire for further education? _____

_____

Have you had any of the following? If yes, when?

3. HISTORY OF:

Diabetes _____ Head Injury _____
Heart Disease _____ Convulsions/D.T.'s _____
Cancer _____ Rhemuatic Fever _____
Lung Disease _____ Surgeries _____
Sexual Dysfuctions _____ Allergies _____
Menopausal/Menstrual Disorders _____
Do you smoke? _____ How much? _____
Current eating patterns (frequent amounts, types of food) _____
_____
Do you believe you are over or under weight? _____

4. VOCATIONAL HISTORY

Employer/Location	Position	Date Started	Date Left	Reason for Leaving

What is your present financial status (general)? _____

Any financial stressors? If so, what? _____

5. MILITARY HISTORY

Previous Armed Forces Experience: [ ] Yes [ ] No Branch of Service: _____

Dates of Service: _____ Type of Discharge: _____

Job in Service: _____

V.A. Hospitalizations or Service: _____

6. LEGAL HISTORY

Month/Year	Location	Offense/ Charge	Disposition	Related to Chemical Use

Do you have any legal problems pending? [ ] Yes [ ] No

If yes, explain: _____

7. RECREATIONAL

Activities, hobbies, interests (past, current, frequency: _____

_____

Have your interests changed? _____

Any physical limitations? _____

8. SPIRITUAL/RELIGIOUS HISTORY

Describe any formal religious/spiritual training or experience you have had:

_____

_____

How did you feel about these experiences? _____

In what way do these experiences or lack of experiences affect your life today?

_____

_____

Describe how you get a sense of serenity and peace: _____

_____

Are there issues related to your religious or spirituality that you would like to address while in treatment? _____

9. ALCOHOL USAGE

Age of first alcohol use: _____

Age you began regular use: _____ Has it caused problems for you: _____

_____

Preferred alcoholic drink: _____

Drinking how often: _____ How much: _____

Previous A.A./N.A. Involvement: _____ How often: _____

Do you have a sponsor? _____

Have you experienced [ ] Blackouts [ ] Tolerance [ ] Solitary Use [ ] Need

10. CHEMICAL HISTORY

Do you feel you have alcoholic/chemical issues? Describe: _____

_____

Previous Chemical Dependency Treatments:

Date	**Place –** **Inpatient./Outpatient., etc.**	**Did you complete?**	**Length of Stay**	**Amount of Sobriety after discharge**

11. PRESENT PHYSICAL HEALTH:

Medical Problems? _____

_____

Last Physical: _____ Current seeing Medical Doctor? [ ] Yes [ ] No

If yes, MD's name: _____ Address: _____

Last seen: _____ Prescribed meds./dosage: _____

Do you exercise regularly? _____ How? _____

Are you experiencing excessive stress in your life? How? _____

_____

Herbal remedies? _____

_____

Alternative medical treatments? Who, when, what: _____

_____

Vitamin supplements? _____

_____