

PERSONAL HISTORY QUESTIONNAIRE

PURPOSE: Please print all your responses in ink and do not leave any blanks. This questionnaire is designed to collect your relevant psychological, sociological, and medical information. This information is used to better understand how to serve you, so that you might learn to problem-solve and cope more effectively in the future. It is important to respond as honest and accurate as possible in order for your counselor to develop a reliable picture of your situation and concerns. If you do not want to answer a question, please write "I do not want to answer that now" in the space provided for your answer. Just guess the season and year for dates you do not remember. Your counselor will review this form with you and retain it along with your other confidential records. Print. Thank you.

SECTION I: Client Identification

DATE: _____ SOCIAL SECURITY NUMBER: _____ COUNSELOR: _____

LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

DATE OF BIRTH: _____ CURRENT AGE: _____ BIRTH PLACE: _____

RACE: _____ SEX: ❑ male ❑ female SCARS: _____

MARITAL STATUS: ❑ never married ❑ cohabitating ❑ engaged ❑ married ❑ separated ❑ divorced ❑ widowed

HEIGHT: _____ WEIGHT: _____ EYE COLOR: _____ HAIR COLOR: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

REFERRAL SOURCE: _____ PREVIOUS ADMISSIONS: ❑ none ❑ yes NUMBER OF: _____

EMERGENCY CONTACT: _____ EMERGENCY CONTACT'S PHONE: _____

SECTION II: Presenting Problems

What brings you to counseling now? _____

What would your spouse, friends, family, parents, and-or the referral source say brings you to counseling?

_____

Have the problems **affected** your: ❑ work functioning ❑ family relations ❑ home environment ❑ friendships ❑ social activities ❑ legal complications ❑ spiritual activities ❑ caused thinking changes ❑ feeling changes ❑ caused behavior changes ❑ caused physical changes ❑ caused any other changes?

PROVIDE DETAILS: _____

_____

How **severe** are the **problems** to you on a scale of 1 to 10 with 10 being the worst?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How severe are the **problems** to you on the word scale below?

❑ uncomfortable ❑ irritating ❑ annoying ❑ upsetting ❑ disturbing ❑ horrible ❑ unbearable ❑ can't stand it

How would you rate your **motivation to change** on a scale of 1 to 10 with 10 being the highest?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How would you rate your **motivation to change** on the word scale below?

❑ none ❑ not much ❑ average ❑ a lot ❑ too much

When did the problems first **begin**? Please give dates (or season of the year) and events.

_____

What was going on just **before** the problems first began?

_____

What were the major life changes near the start of the problem?

_____

When have **similar** problems occurred?

_____

What have you done in the past to **handle** similar problems?

_____

What has **worked** to help with these problems?

_____

What has **not worked** to help with these problems?

_____

How will everything **be different** when the problems are gone?

_____

What do you want to **improve** first?

_____

YES	NO	STRESSOR	YES	NO	STRESSOR
y	n	age milestone 20/30/40/50/60/70	y	n	death of close family member
y	n	begin or end school	y	n	death of close friend
y	n	change in any major patterns	y	n	death of spouse
y	n	change in arguments with significant	y	n	detention in institution
y	n	change in behavior of family member	y	n	divorce
y	n	change in business	y	n	fired from job
y	n	change in church activities	y	n	foreclosure of loan
y	n	change in eating habits	y	n	getting married
y	n	change in financial state	y	n	hospitalization for illness/injury
y	n	change in health of family member	y	n	in-law problems
y	n	change in living conditions	y	n	loan greater than $10,000
y	n	change in number of family events	y	n	marital reconciliation
y	n	change in recreation	y	n	marital separation
y	n	change in residence	y	n	minor law violation
y	n	change in sleep pattern	y	n	mortgage greater than $10,000
y	n	change in social activities	y	n	moving
y	n	change in work conditions	y	n	new person living with you
y	n	change in work duties	y	n	outstanding personal accomplishment
y	n	change in work hours	y	n	pregnancy
y	n	change of personal habits	y	n	retirement
y	n	change of schools	y	n	sexual problems
y	n	change of work	y	n	spouse beginning/ceasing work
y	n	child leaving home	y	n	stressful job
y	n	Christmas	y	n	transportation problems
y	n	conflict with boss	y	n	vacation

What is in the way of your solutions to these problems such as stressors, obstacles, pressures, and-or challenges?

_____

Have you ever had professional help with any of these problems before? Please list the last three if more than three.

1) WHO: _____ WHERE: _____ WHEN: _____ HOW LONG: _____

WHAT RESULTS: _____

2) WHO: _____ WHERE: _____ WHEN: _____ HOW LONG: _____

WHAT RESULTS: _____

3) WHO: _____ WHERE: _____ WHEN: _____ HOW LONG: _____

WHAT RESULTS: _____

What is your **view of counseling**? Please check all that apply.

❑ support for your point of view ❑ protection from others or the world ❑ permission to do what you want/need
❑ permission to change ❑ power to change ❑ supportive friendship/listening ❑ role model for improved living
❑ opportunity to gain insight into your motives ❑ help to change habits ❑ education/insight about relationships
❑ support for switching from ineffective behaviors ❑ learning new skills ❑ education/insight about emotions

What is your view of the **source of your problems**? Please check all that apply.

❑ I do not have any problems ❑ others have problems ❑ others cause my problems ❑ life causes my problems
❑ I contribute to my problems ❑ I'm the cause of my problems ❑ I want to change others ❑ I want to change me
❑ I want to change my life ❑ I want to rewrite my life ❑ I want to relearn coping and problem-solving

What is your view of the best way to **deal with your problems**? Please check all that apply.

❑ best to ignore them ❑ best to forget them ❑ best to exchange them ❑ excuse your behaviors because of them
❑ best to cope with them ❑ best to problem-solve them ❑ find out who caused them ❑ stop those who cause them
❑ punish those who cause them ❑ you learned them ❑ you can unlearn them ❑ you can learn to do differently
❑ I am doing the best I can with the skills I have ❑ learn new coping skills ❑ learn new problem-solving skills

Who were you raised by? From when to when?

Were they your biological parents? ❑ yes ❑ no

HOW CLOSE WAS YOUR FAMILY THEN: ❑ far apart ❑ somewhat close ❑ close ❑ very close ❑ too close

HOW DID THEY RESPOND TO CHANGES: ❑ things just happened ❑ took things as they came ❑ planned for change ❑ resisted change ❑ denied change

What are the names, ages, and living locations of your **fathers**?

How did you get along with your fathers growing up and now?

What was your father's occupation while you were growing up and now?

What are the names, ages, and living locations of your **mothers**?

How did you get along with your mothers growing up and now?

What was your mother's occupation while you were growing up and now?

What are the names, ages, and living locations of your **brothers**?

How did you get along with your brothers growing up and now?

What are the names, ages, and living locations of your **sisters**?

How did you get along with your sisters growing up and now?

What are the names, dates, ages, and cities of your **marriages or partners**?

What were the dates and reasons for **divorces** and-or major **breakups**?

What are the names, dates of birth, and living locations of your **children** including stepchildren?

How were the **rules** maintained or enforced (types of punishments) when you were growing up?

Are any family members **cutoff**, blocked, or disowned from any other members?

Are any family members ganging up on, picking on, or **attacking** any other family members?

What is the **health** of the members of your family of origin?

If any family members have **died**, please report the dates and causes of death.

What was your age and **response** to the death of each family member who died?

Do you consider yourself to be of any particular **race** or ethnic group?

In what ways is membership in this race or ethnic group **important** to you?

What **religious** or spiritual training were you given as a child?

What religious or spiritual **training** do you seek now and-or find important now?

Does your membership in this race or **ethnic** group have anything to do with your problems?

When **growing up**, did you have any problems with any of the following?
delayed development? ❑ yes ❑ no crawling? ❑ yes ❑ no walking? ❑ yes ❑ no talking? ❑ yes ❑ no
❑ do not know or DETAILS: _____
Did you experience any **abuse** while growing up?
not being properly cared for (neglect)? ❑ yes ❑ no physical abuse? ❑ yes ❑ no sexual abuse? ❑ yes ❑ no
verbal abuse? ❑ yes ❑ no emotional abuse? ❑ yes ❑ no other forms of abuse? ❑ yes ❑ no

What **problems** did you have growing up? Check the boxes and explain any check mark answers afterward.
school? ❑ yes ❑ no grades? ❑ yes ❑ no skipped school? ❑ yes ❑ no home? ❑ yes ❑ no church? ❑ yes ❑ no
runaway? ❑ yes ❑ no pregnancy? ❑ yes ❑ no fire setting? ❑ yes ❑ no lying? ❑ yes ❑ no fights? ❑ yes ❑ no
used weapons in fights? ❑ yes ❑ no destruction of property? ❑ yes ❑ no cruelty to animals? ❑ yes ❑ no

Have you had any special education classes? ❑ yes ❑ no learning disabilities? ❑ yes ❑ no handicaps? ❑ yes ❑ no
EXPLAIN: _____

How did you get along with **grade school** teachers? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
How did you get along with **high school** teachers? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
How did you get along with **college** teachers? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
How did you get along with **grade school** students? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
How did you get along with **high school** students? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
How did you get along with **college** students? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
What was your **grade average** in grade school? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
What was your grade average in high school? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
What was your grade average in college? ❑ terrible ❑ poor ❑ average ❑ good ❑ great
Please list all degrees, trade schools, certificates, and training programs attempted and completed with dates:

What current and-or **future** schooling plans do you have?

Did you have any jobs to make money as a child? ❑ neighborhood jobs ❑ shoveling snow ❑ selling lemonade
❑ odd jobs ❑ gardening ❑ paper route ❑ car washing ❑ raking leaves ❑ other
PROVIDE DETAILS: _____
What is your adult work history? Please include types and numbers of jobs.

What kinds of work have you enjoyed?

What is your current employment?

What are your future plans for employment?

Have you ever been fired from a job? ❑ yes ❑ no How many times? _____
Have you ever quit a job? ❑ yes ❑ no How many times? _____
What are your job skills? _____
What is your job security if any? _____
Have you ever served in the military? ❑ yes ❑ no
BRANCH: _____ SEEN COMBAT: _____ PAY GRADE: _____ DATES OF SERVICE: _____
DISCHARGE STATUS: _____ DUTY: _____

Are you currently in a **sexual relationship**? ❑ yes ❑ no Is it satisfactory? ❑ yes ❑ no
What is your past sexual orientation? ❑ heterosexual ❑ homosexual ❑ bisexual ❑ asexual ❑ celibate
What is your present sexual orientation? ❑ heterosexual ❑ homosexual ❑ bisexual ❑ asexual ❑ celibate
What is your future sexual orientation? ❑ heterosexual ❑ homosexual ❑ bisexual ❑ asexual ❑ celibate
How did you first learn about sex? _____
When did you first become sexually active? _____
Have you ever been forced to have sex? _____
Have you ever paid for sexual favors? _____
Are you experiencing any loss of sexual desire or ability to perform? _____
What is the date of your menstruation or menopause? _____
How many close friends do you have? (Close being, for example, someone who would loan you $100 and listen to you whine for an hour.) ❑ none ❑ a few ❑ several ❑ many ❑ a lot
Do you have any close relatives in the area? ❑ yes ❑ no Are they part of your support system? ❑ yes ❑ no
Are you involved in your community in any way? ❑ yes ❑ no

_____
What are your hobbies, interests, and leisure time activities?

_____
Do you belong to any groups? ❑ yes ❑ no

_____
Have you ever belonged to any groups that were hard to leave, controlling, or punishing? ❑ yes ❑ no

_____
What is your current living situation?
❑ apartment ❑ home ❑ condo ❑ buying ❑ renting number of bedrooms: ❑ 1 ❑ 2 ❑ 3 ❑ more
Who lives with you? _____
What is the source of your income and are there any financial concerns? _____
What insurance do you carry? ❑ health ❑ disability ❑ retirement ❑ life ❑ homeowner's ❑ renter's
Have you ever been arrested? ❑ yes ❑ no
REASON: _____ CHARGES: _____ DATES: _____ SENTENCES: _____
OUTCOMES: _____ JAIL: _____ PRISON: _____ PROBATION: _____ PAROLE: _____
REASON: _____ CHARGES: _____ DATES: _____ SENTENCES: _____
OUTCOMES: _____ JAIL: _____ PRISON: _____ PROBATION: _____ PAROLE: _____
REASON: _____ CHARGES: _____ DATES: _____ SENTENCES: _____
OUTCOMES: _____ JAIL: _____ PRISON: _____ PROBATION: _____ PAROLE: _____
Are there any current legal concerns? _____

_____
Are you court ordered to treatment? _____
Describe yourself with single words or short phrases: strengths, weaknesses, self-worth.

_____

_____

SECTION IV: Health History

Who is your physician, family doctor, or clinic (name, address, phone)?

_____
When was the last time you saw them and what for?

_____
Do you have any mental or physical **disabilities**?

_____
Is there a family history of medical concerns? ❑ cancer ❑ high blood pressure ❑ heart disease ❑ genetic ❑ other
PROVIDE DETAILS: _____
Is there a **family history** of mental-health problems? ❑ depression ❑ anxiety ❑ nervous breakdowns
❑ hospitalizations ❑ suicide attempts ❑ other DETAILS: _____
Do you eat 5 servings of fruits and vegetables almost every day? ❑ yes ❑ no
Do you eat at about the same times each day? ❑ yes ❑ no
Have you experienced any recent **weight gain** or loss? ❑ yes ❑ no If yes then how much? _____
Do you enjoy eating? ❑ yes ❑ no
How do you get your exercise? _____
How many hours of **sleep** do you normally get? ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12 hours

Do you normally take **naps** and for how long? ❑ yes ❑ no ❑ 1 ❑ 2 ❑ 3 ❑ 4 hours

Do you experience frequent waking or tossing and turning? ❑ yes ❑ no If yes then how often? _____

How would you rate your **energy level** on a scale from 1 to 10 with 10 being the highest?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How would you rate your **energy level** on the word scale below?

❑ none ❑ not much ❑ average ❑ a lot ❑ too much

How would you rate your **activity level** on a scale from 1 to 10 with 10 being the highest?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How would you rate your **activity level** on the word scale below?

❑ none ❑ not much ❑ average ❑ a lot ❑ too much

How would you rate your **enjoyment level** on a scale from 1 to 10 with 10 being the highest?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How would you rate your **enjoyment level** on the word scale below?

❑ none ❑ not much ❑ average ❑ a lot ❑ too much

How would you rate your **health** on a scale from 1 to 10 with 10 being the highest?

❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

How would you rate your **health** on the word scale below?

❑ terrible ❑ poor ❑ average ❑ good ❑ great

Why did you rate your **health** the way that you did?

_____

Are you very concerned about any physical problems or symptoms?

_____

Are you allergic to or have you ever had an allergic reaction to any medications?

_____

Are you sensitive to or have you ever had any negative reactions to any medications?

_____

List all prescribed medications taken in last 6 months. Already reported on intake medication sheet: ❑ yes ❑ no

_____

List all over-the-counter medications that you take. Already reported on intake medication sheet: ❑ yes ❑ no

_____

After answering "yes" or "no" for all the following, please provide more information on all your "yes" answers.

YES	NO	CONDITION	YES	NO	CONDITION	YES	NO	CONDITION
y	n	Aids	y	n	Head Injuries	y	n	Pneumonia
y	n	Allergies	y	n	Headaches	y	n	Polio
y	n	Arthritis	y	n	Heart Disease	y	n	Problematic Childbirth
y	n	Asthma	y	n	Herpes	y	n	Prostatitis
y	n	Back Pain	y	n	High Blood Pressure	y	n	Respiratory Infections
y	n	Boils/Rashes	y	n	Hospitalizations	y	n	Rheumatic Fever
y	n	Brain Injuries/Trauma	y	n	Impaired Circulation	y	n	Seizures
y	n	Broken Bones	y	n	Infections	y	n	Severe Vomiting
y	n	Convulsions	y	n	Irregular menstrual cycle	y	n	Shortness of Breath
y	n	Dermatology/skinproblem	y	n	Jaundice	y	n	Sleeping Sickness
y	n	Diabetes/Sugar intolerant	y	n	Kidney Disease	y	n	Spinal Cord Injuries
y	n	Disorientation	y	n	Nervous Condition	y	n	Spinal Meningitis
y	n	Dry Mouth	y	n	Neurological Problems	y	n	Stitches
y	n	Emergency Room Visits	y	n	Nose/Gums Bleeding	y	n	Strep Throat
y	n	Encephalitis	y	n	Operations	y	n	Syphilis or other STDs
y	n	Exposure to CNS Toxins	y	n	Others Not Mentioned	y	n	Tonsillitis
y	n	Fainting/Dizziness	y	n	Painful Menstrual Cycle	y	n	Tuberculosis
y	n	Gastrointestinal Concerns	y	n	Palpitations	y	n	Unconsciousness
y	n	Gonorrhea	y	n	Persistent Chest Pain	y	n	Unusual/heavy bleeding
y	n	Gout	y	n	Persistent Pain	y	n	Urinary Tract Infection

PROVIDE DETAILS: _____ (v.8)

Have you had any significant **accidents** or illnesses that were not covered above? Please explain.

At what age did you start to use caffeine (coffee, tea, or caffeinated pop)? _____
What was your childhood usage like? _____
What is your adult usage like? _____

At what age did you start to use nicotine (tobacco, chew)? _____
What was your childhood usage like? _____
What is your adult usage like? _____

At what age did you start to use alcohol? _____
What was your childhood usage like? _____
What is your adult usage like? _____

At what age did you start to use marijuana? _____
What was your childhood usage like? _____
What is your adult usage like? _____

At what age did you start to use illegal drugs and which ones? _____
What was your childhood usage like? _____
What is your adult usage like? _____

Have you ever had a DWI or OWI? ❑ yes ❑ no
DETAILS: _____

Have you ever had any drug or alcohol evaluations or treatments? ❑ yes ❑ no
If "yes" then when, where, and with what outcomes or completions? _____

Have you ever felt that you should cut down on your drinking or drugging? ❑ yes ❑ no
DETAILS: _____
Have people annoyed you by criticizing your drinking or drugging? ❑ yes ❑ no
DETAILS: _____
Have you ever felt bad or guilty about your drinking or drugging? ❑ yes ❑ no
DETAILS: _____
Have you ever had a drink or a drug first thing in the morning to steady your nerves or to get over a hangover?
❑ yes ❑ no DETAILS: _____
Have you ever been to support groups such as AA, NA, CA, GA, OA, Al-Anon? ❑ yes ❑ no

Do you now or have you had in the past any compulsions that you could not control such as eating, gambling, sexing, spending, interneting, shoplifting? ❑ yes ❑ no
DETAILS: _____
Is there anything you would like to add to your social history now that you are at the end?

Client's Signature Date Signed

