



Personal History Form

Name: _____ DOB: _____ Date: _____

What is the problem/concern(s)? _____

How long has this been going on? _____

Current Signs & Symptoms (please check box [X] for mild, moderate, or severe if symptom is present for you)

Mild: Impacts quality of life, but no significant impairment of day-to-day functioning • Moderate: Significant impact of quality of life and/or day-to-day functioning • Severe: Profound impact on quality of life and/or day-to-day functioning

Table with 3 columns (Mild, Moderate, Severe) and 30 rows of symptoms including depressed mood, appetite disturbance, sleep disturbance, etc.

Functional Status

Table with 4 columns for functional status categories: Activities of Daily Living, Mobility, Vision, Hearing, Nutrition.

Financial Situation

Table with 3 columns for financial situation categories: Finances, Spending.



- Debt No problems Concerns but managing Problematic
 Sources of income Employment Spouse's employment SSI SDI/SSD
 Retirement/savings/other

Housing and Living Situation

- Adequate Homeless Overcrowded Dependent on others Conflict w/ living companions

Current Relationship and Family Functioning

- Single Married Divorced Separated Domestic partnership Widowed
 Currently in a relationship

Relationship Satisfaction: Satisfied Somewhat satisfied Dissatisfied

Sexual Orientation: Heterosexual Gay/lesbian Bisexual

Name of Children	Age	Gender	Lives at (home/away)	Quality of Relationship with client (good/fair/poor)

Name of Others Living in the home	Age	Gender	Relationship to client	Quality of Relationship with client (good/fair/poor)

How is your family getting along?

Medications and Supplements (please list prescription and over-the-counter medications, vitamins, & supplements)

Are you taking the above "as prescribed"?

Medical and Surgical History (please list significant medical problems and surgeries)



Mental Health History

(please list any diagnoses, therapy, treatment, and medications)

Any suicidal thoughts or attempts? If so, when?

Have you ever been hospitalized in a psychiatric hospital? If so, when? Reason?

Family of Origin

(your family during your childhood)

Mother:

Father:

Siblings:

Other significant figures:

What birth order are you?

List relevant medical and surgical history:

List any mental health concerns, medications, & treatment:

How would you describe your childhood?

Educational and Employment Background

Highest grade level completed:

List learning or behavior problems in school?

Employed

Unemployed due to disability

Unemployed/chooses to work

Retired

Unemployed/chooses not to work

Employer: _____

Occupation: _____

Hours worked per week: _____

Military Service Served/No Incident Served/With Incident Branch: _____

Social Cultural History

Birthplace:

List any delays in reaching your developmental milestones (walking, talking, etc.)?

Exposure to abuse: Physical Verbal Emotional Sexual Neglect

Length of time in local area:

Religion/spirituality:

Ethnicity/Cultural factors:

Identity Issues:

Disabilities:

Hobbies and activities:

Exercise:

Substance Use History

(please list prescription, illicit, legal, & recreational substances)

List any substance misuse treatment? For what? When?



Legal History

Jail Prison Parole Probation Court ordered treatment

Reason:

Other Agencies or Systems Involved

(social services, court, etc.)

Desired Result of Therapy/Services

(what do you want to get out of this?)

Protective Factors – Strengths

Support person/system:

Current coping strategies:

Other

Is there anything you would like me to know about you?

Any questions for me?