Alaska Center for Counseling

Personal History

Client's Name: ______________________________ Date: ________________________

Gender: ____M ____F Date of Birth: ___/___/____ Age:__________________

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

Address: ________________________City: _____________State:______ Zip:_______

Phone (home): _______________________ (work):__________________________

Emergency contact name: ____________________________Phone: _______________

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

Primary reason (s) for seeking services:

____

____

Family History

Name	Age	Living/Deceased	Living w/you?
Mother____________________	________	______________	____________
Father_____________________	________	______________	____________
Spouse or S/O ______________	________	______________	____________
Children ___________________	________	______________	____________

Children ____________________ ________ ______________ ______

____________________ ________ ______________ ______

____________________ ________ ______________ ______

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

Relationship: Name	Age	Living/Deceased	Living w/you
______________________________	____	______________	___________
______________________________	____	______________	___________
______________________________	____	______________	___________
______________________________	____	______________	___________

Marital Status

(more than one answer may apply)

Single_______ Divorce in process________ Unmarried, living together__________
Length of time: __________ Length of time: __________________

Legally married _______ Separated___________ Divorced____________________
Length of time:_______ Length of time: ______ Length of time: ______________

Assessment of current relationship (if applicable):

Good _________ Fair ____________ Poor______________________

Number of marriages:____________

Parental Information

___Parents legally married ____Mother remarried: Number of times:___

___Parents have never been separated ___Father remarried: Number of times:___

___Parents 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:

____

____

____

____

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: ______________________________

Current Legal 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:

____

DWI, DUI, etc.,: ____Yes _____No

Education

Fill in all that apply:
Years of education: ____ Currently enrolled in school? ____Yes ____

____ 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):

____

____

Current Employment Status and Occupation

____

____

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

_____HIV/AIDS
_____Alcoholism
_____Abdominal pain
_____Abortion
_____Allergies
_____Anemia
_____Appendicitis
_____Arthritis
_____Asthma
_____Bronchitis
_____Bed wetting
_____Cancer
_____Chest pain
_____Chronic pain
_____Colds/cough
_____Constipation
_____Chicken pox
_____Dental problems
_____Diabetes
_____Diarrhea

_____Dizziness
_____Drug abuse
_____Epilepsy
_____Ear infections
_____Eating problems
_____Fainting
_____Fatigue
_____Frequent urination
_____Headaches
_____Hearing problems
_____Hepatitis
_____High blood pressure
_____Kidney problems
_____Measles
_____Mononucleosis
_____Mumps
_____Menstrual pain
_____Miscarriages
_____Neurological disorders
_____Nausea

_____Nose bleeds
_____Pneumonia
_____Rheumatic fever
_____STD's
_____Sleeping disorders
_____Sore throat
_____Scarlet Fever
_____Sinusitis
_____Smallpox
_____Stroke
_____Sexual problems
_____Tonsillitis
_____Tuberculosis
_____Toothache
_____Thyroid problems
_____Vision problems
_____Vomiting
_____Whooping cough
_____Other (describe):
_____Heart disease

Medical/Physical Health – Continued

List any current health concerns: ____

____

List any recent health or physical changes: ____________________________________

____

Current prescribed medications: 1____

2____

3____

4____

1. Dose: ______ Dates: ______ Purpose: ___________ Side effects: ____________
2. Dose: ______ Dates: ______ Purpose: ___________ Side effects: ____________
3. Dose: ______ Date: _______ Purpose: ___________ Side effects: ____________
4. Dose: ______ Date: _______ Purpose: ___________ Side effects: ____________

Current over-the-counter medications: 1_____________________________________

2_____________________________________

3_____________________________________

4_____________________________________

1. Dose: ______ Dates: _______ Purpose: __________ Side effects: ____________
2. Dose: ______ Dates: _______ Purpose: __________ Side effects: ____________
3. Dose: ______ Dates: _______ Purpose: __________ Side effects: ____________
4. Dose: ______ Dates: _______ Purpose: __________ Side effects: ____________

Are you allergic to any medications or drugs? ________ Yes ________No

If yes, describe: ____

Last physical exam date: ____

Reason: ______________________ Results: ______________________

Last doctor's visit: ____

Reason: ______________________Results: ______________________

Last vision exam: ____

Reason: ______________________ Results: ______________________

Last hearing exam: ____

Reason: ______________________ Results: ______________________

Most recent surgery: ____

Reason: ______________________ Results: ______________________

Other surgery: ____

Reason: ______________________ Results: ______________________

Upcoming surgery: ____

Reason: ______________________ Results: ______________________

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

Alcohol, Barbiturates, Valium/Librium, Cocaine/Crack, Heroin/Opiates, Marijuana, PCP/LSD, Inhalants, Caffeine, Nicotine, over the counter, Prescription drugs, other drugs.

Name: ____

Frequency of use: ____________________________________

Method of use and amount: ______________________________

Age of first use: ________________________

Age of last use: ________________________

Used in last 48 hours: ____________________

Used in last 30 days: _____________________

Name: ____

Frequency of use: ____________________________________

Method of use and amount: ______________________________

Age of first use: ________________________

Age of last use: ________________________

Used in last 48 hours: ____________________

Used in last 30 days: _____________________

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):

____

How do you believe your substance use affects your life?

____

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

____

Does or has someone in your family, present or past have or 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: ________

____

Have you blacked out from alcohol? ________Yes ________No

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	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	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	_____Elevated mood	_____Phobias/fears
_____Alcohol dependence	_____Fatigue	_____Recurring thoughts
_____Anger	_____Gambling	______Sexual addiction
______Antisocial behavior	_____Hallucinations	______Sexual difficulties
______Anxiety	_____Heart palpitations	______Sick often

______Avoiding people	______High blood pressure	_____ Sleeping problems
______Chest pain	______Hopelessness	_____ Speech problems
______Cyber addiction	______Impulsivity	_____ Suicidal thoughts
______Depression	______Irritability	_____Thoughts disorganized
______Disorientation	______Judgment errors	_____ Trembling
______Distractibility	______Loneliness	_____Withdrawing
______Dizziness	______Memory impairment	______Worrying
______Drug dependence	______Mood shifts	______Other (specify):
______Eating disorder	______Panic attacks	

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: ____

____

____