Douglas County Public Health Services Group, Inc.

ADULT PERSONAL HISTORY
(18 years and older)

Client Name: _____ ID#:_____ Date:_____
Person completing form: _____

Please take your time and complete entire form. The information will help your therapist understand you better. Use the back of last sheet of this form if necessary.

FAMILY HISTORY
IMMEDIATE FAMILY

Marital Status:
[] single, never married
[] engaged ___months
[] married for ___years
[] divorced for ___years
[] separated for ___years
[] divorce in process ___months
[] live-in for ____years
[] ___prior marriages (self)
[] ___prior marriages (partner)

Intimate relationship:
[] never been in a serious relationship
[] not currently in relationship
[] currently in a serious relationship

Relationship satisfaction:
[] very satisfied with relationship
[] satisfied with relationship
[] dissatisfied with relationship
[] very dissatisfied with relationship

List all persons living in the home:

Name	Age	Relationship
_____	___	_____
_____	___	_____
_____	___	_____

List children not living in same home:

_____	___	_____
_____	___	_____
_____	___	_____

Frequency of visitation? _____

FAMILY OF ORIGIN

Present during childhood:

	Present Entire Childhood	Present part of Childhood	Not present at all
Mother	[]	[]	[]
Father	[]	[]	[]
Stepmother	[]	[]	[]
Stepfather	[]	[]	[]
Brother(s)	[]	[]	[]
Sister(s)	[]	[]	[]
Other(specify)	[]	[]	[]

Parents' current marital status:
[] married to each other
[] separated for ___years
[] divorced for ___years
[] mother remarried ___times
[] father remarried ___times
[] mother involved with someone
[] father involved with someone
[] mother deceased for ___years
[] father deceased for ___years

Describe parents:

	Father	**Mother**
full name	_____	_____
occupation	_____	_____
education	_____	_____
general health	_____	_____

Describe childhood family experience:
[] outstanding home environment
[] normal home environment
[] chaotic home environment
[] witnessed physical/verbal/sexual abuse
[] experienced physical/verbal/sexual abuse

Number of brothers/sisters: _____ # living: _____ # older than you: _____

Family member you are close to now: _____

Presenting Problems	**For How Long?**	**Additional Information**
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)
None = This symptom not present at this time **Mild** = Impacts quality of life, but no significant impairment of day to day functioning
Moderate = Significant impact on quality of life and/or day to day functioning **Severe** = Profound impact on quality of life

___Depression
___Crying spells
___Hopelessness
___Relationship breakup
___Loneliness
___Emptiness
___Loss of appetite
___Sleep problems
___Nightmares
___Thoughts of harming self
___Thought of harming other
___Suicide attempts/injuries
___Hearing voices
___Seeing things others don't
___Unusual thoughts

___Increased alcohol use
___Increased drug usage
___Blackouts/memory loss
___Withdrawal symptoms
___Financial Worries
___Loss of control in :
___-alcohol/drug use
___-overeating/bingeing
___-purging
___-yelling/breaking
___-hitting people
___-endangering self
___-endangering others
___-spending
___-gambling

___Nervous/anxious
___Panic attacks
___Can't concentrate
___Confusion
___Mood swings
___Racing thoughts
___Fear of dying
___Job stress
___Decreased activity
___Not seeing friends
___Feel controlled
___Feel talked about
___Guilt/shame
___Sexual problems
___School problems

Have you ever attempted to commit SUICIDE or seriously harm yourself?_____

If so, when? _____ How? _____

Anyone in your family attempted suicide? _____ Committed suicide?____ Who?_____
Explain:_____

Have you ever attempted to kill or seriously harm someone else?_____ Who?_____
Explain:_____

Have you ever hit, slapped or choked any of your loved ones?_____

During arguments/fights do you threaten, throw or break things, punch the walls or slam doors, yell or scream at your partner or children?_____
Describe:_____

Is your partner afraid of you sometimes? _____ Are your children? _____

Do you feel guilty about your behavior afterward?_____

Have you ever been the victim of physical, sexual or verbal abuse? _____
Describe: _____
_____

Describe any sexual concerns you might have: _____
_____

PREVIOUS MENTAL HEALTH TREATMENT:

Were you ever HOSPITALIZED for depression, hearing voices, substance use disorder, or other emotional disorder?_____

How many times?____ Any Involuntary?____ Year of first admission:____ Where:_____

Reason: _____

Year of last admission:____ Where:_____

Reason: _____

Have you received any OUTPATIENT Mental Health counseling? _____

Where/When: _____

Reason: _____

Have you ever been involved in any support groups (Emotions Anonymous, Recovery, Weight-Watcher, Incest Survivors, ACOA, Alanon, etc.)?_____ When?_____ Where:_____
Reason:_____ Was it helpful?_____

Has anyone in your family ever been hospitalized for depression or any other mental or emotional problems? Please explain who, when and reason: _____

_____

_____

_____

ETHNIC Background:_____
Any ethnic problems/concerns? _____

RELIGIOUS/SPIRITUAL Background:_____
Current religious/spiritual activity:_____
Do you have any spiritual concerns now?_____

EDUCATION: Last grade completed:____ Degree_____ In school now?_____
Special training or skills:_____
Hope/plan to go to school:_____
Have a learning difficulty:_____

EMPLOYMENT: What do you do for a living?_____
Employer:_____ Years on job:_____ Pay rate:_____
If no job, when did you last work?_____ Looking for work now? _____
Any job problems now?_____
Ever been fired?_____ How many times:_____ Why?_____

FINANCIAL: Do you have any financial problems? _____
What financial aid do you receive?_____ Amount:_____

What aid do family members get?_____ Amount:_____

LEGAL HISTORY: [] No legal history

Arrest Date	Charge	Convicted?	Sentence

Are you currently on Probation?_____ Parole? _____ Ending Date:_____
Are you involved in any lawsuits?_____
Any upcoming Court dates?_____

MILITARY SERVICE: Type: _____ When: _____
Honorable discharge? _____ If not, why? _____
Describe any combat experience:_____
Are you troubled now by your experience in the military?_____

INTERESTS/ACTIVITIES (Circle or check all that apply):

Television	Be with friends	Shopping	Fix/repair things
Movies/videos	Be with family	School	Sew/knit/crochet
Music listening	Be alone	Get high	Build/decorate
Play instrument	Cooking/eating	Exercise	Gardening
Singing	Go to museums	Play sports	Photography
Dancing	Volunteer work	Watch sports	Video games
Reading	Travel/sight-see	Hiking	Care for elderly
Writing	Prayer/Church	Gambling	Child-care
Drawing	Camping	Sex	Nothing

Other interests/activities:_____

Have you recently lost interest in activities you normally enjoy?_____

Do you feel you spend enough time on your interests or non-work activity?_____

PHYSICAL HEALTH:

(Circle the number for each item that applied to you in the past or now and explain below):

1. Allergies
2. Asthma
3. Ulcers
4. Cancer
5. Stomach problems
6. Pancreatitis
7. Chronic pain
8. Heart disease
9. Bacterial endocarditis
23. Severe headaches/migraines
24. Frequent neck/shoulder pain
25. Head injuries
26. Physical Abuse
27. Sexual Abuse
28. Premenstrual syndrome
29. Sexually transmitted diseases
30. Positive HIV
31. AIDS

10. Seizures
11. High Blood Pressure
12. Low Blood Pressure
13. Diabetes
14. Hypoglycemia (low blood sugar)
15. Thyroid Problems
16. Liver Disease
17. Vision problems
18. Hearing problems
19. Speech problems
20. Dental problems
21. Weight loss
22. Weight gain
32. Tuberculosis
33. Hepatitis
34. Major surgeries
35. Chronic fatigue syndrome
36. Impotence
37. Prolapsed mitral valve
38. Circulation problems
39. High Cholesterol
40. Irritable bowel
41. Broken bones
42. Accidents
43. Other _____

#	At what ages?	Describe problem and treatment (include medications):
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____
___	_____	_____

Date of last physical: _____ Results: _____
Do you eat a regular balanced diet? _____ Do you skip meals? _____
Any poor eating/junk food habits? _____
Do you exercise regularly?_____ How often? _____

FOR WOMEN: Number of pregnancies?_____ Live births:_____ Adoptions:_____
Normal menstrual cycle?_____ Are you pregnant?_____
Premenstrual syndrome?_____ Menopause?_____ Hormone therapy?_____

ALCOHOL AND DRUG USE HISTORY:
How many days a month do you drink_____ or use non-prescribed drugs?_____
On the days that you drink or use drugs, about how much do you drink in ounces (including beer) or use in drugs?_____
How many times a month do you drink more than you planned to?_____

Do you ever experience blackouts (memory lapses) when drinking?_____
Have you ever overdosed _____ or experienced withdrawal symptoms?_____
Explain:_____
How much alcohol and drugs have you used in the last 48 hours?
Alcohol_____ Drugs_____
What is the longest period you remained totally alcohol/drug-free?_____
What helped you to stay clean?_____

Treatment History:
Did you ever receive HOSPITAL or RESIDENTIAL treatment for an alcohol or drug-related problem?_____

How many times?_____
When/Where:_____ Helpful?_____
Have you ever received any OUTPATIENT alcohol/drug treatment?_____
When/Where:_____ Helpful?_____
Ever involved in alcohol/drug Support groups (AA, NA,etc.)?_____
When/Where:_____ Helpful?_____

Family alcohol/drug abuse history:

[] father	[] stepparent/live-in	[] uncle(s)/aunts(s)
[] mother	[] spouse/significant other	[] grandparent(s)
[] siblings	[] children	[] other _____

Substances Used: (Complete all that apply)	First use age	Last use age	Current use (yes/no)	Frequency	Amount
[] alcohol	_____	_____	___	_____	_____
[] amphetamines/speed	_____	_____	___	_____	_____
[] barbiturates/owners	_____	_____	___	_____	_____
[] caffeine	_____	_____	___	_____	_____
[] cocaine	_____	_____	___	_____	_____
[] crack cocaine	_____	_____	___	_____	_____
[] hallucinogens (e.g., LSD)	_____	_____	___	_____	_____
[] inhalants (e.g., glue, gas)	_____	_____	___	_____	_____
[] marijuana or hashish	_____	_____	___	_____	_____
[] nicotine/cigarettes	_____	_____	___	_____	_____
[] PCP	_____	_____	___	_____	_____
[] prescription_____	_____	_____	___	_____	_____
[] Other_____	_____	_____	___	_____	_____

Consequences of substance abuse (check all that apply)

[] hangovers	[] withdrawal symptoms	[] sleep disturbance	[] binges
[] seizures	[] medical conditions	[] assaults	[] job loss
[] blackouts	[] tolerance changes	[] suicidal impulse	[] arrests
[] overdose	[] loss of control amount used	[] relationship conflicts	

[] other _____

Therapist/Credentials:_____ Date:_____