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PERSONAL HISTORY QUESTIONNAIRE

PATIENT NAME: ____________________ AGE: ______ DATE OF BIRTH: ________ TODAYS DATE: _________
SOCIAL SECURITY NUMBER: ______________________________ PLACE OF BIRTH: ____________________________
GENDER: ❑Male ❑ Female HEIGHT: ____________________ WEIGHT: __________________________
RACE: ❑African American ❑ Native American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other: ______________________
MARITAL STATUS: ❑Single ❑Engaged ❑Married ❑Remarried ❑Separated ❑Divorced ❑Widowed ❑Living w/ partner

Please describe the problem: ____
____
How severe are these problems? ❑Mild ❑Moderate ❑Severe ❑Extreme ❑Unable to function
How long have you had these problems? ___________________ Are they: ❑on-going or do they ❑come and go?

MEDICAL HISTORY: *Please list any current medical problems: ____*
____
From whom or where do you get medical care? Name________________________ Phone: _________________________
Dates & Types of recent Surgeries or Hospitalizations: ____
____
Seizures: ❑Yes ❑No Allergies: ____
Have you ever experienced a severe accident or injury of any kind? ❑Yes ❑No When? ___________________________
What type of accident? _________________________ Where was your injury? __________________________________
How long were you hospitalized? ____________ Did you lose consciousness? ❑Yes ❑No How Long? _____________
How did this accident or injury affect your life/functioning? ____
Please describe any others you might have had. ____
____

Please List All Medications Currently Prescribed for You (List additional on back):

Name of Medication	*Dosage*	*When Started*	*Name of Doctor*	*Is It Helping?*

CURRENT LIVING ARRANGEMENTS: *(Names, ages, and relationship, of those living with you): __________________*
____
Name of current partner: *____ Age: ___________________________*
Are you experiencing problems in this relationship? (Please describe briefly): ___________________________________
____ Length of relationship: ____________# of Children: ___________
Please list previous marriages: *(Name and Year): _______________ Length of marriage: ________ # of children: _____*
Name & Year _______________________ Length of marriage: ______________# of Children: ______________________

CHILDREN'S NAMES AND AGES (List additional on back):

Name	***Age***	***Gender***	***Relationship (bio., step)***	***Custody?***	***Living at home?***

OCCUPATIONAL HISTORY: *What is your current work status?* ❑ *Employed full-time/part-time* ❑ *Retired* ❑ *student*

What is your current occupation? ______________________________ *How long at this location?* __________

Do you feel your symptoms are affecting your ability to work? ❑ *Yes* ❑ *No* *In what way?* ______________________

____

Are you currently on disability? ❑ *Yes* ❑ *No* *What type of disability?* ______________________________

Who signed your release from work? ______________________ *When did you begin your disability?* ______________

MENTAL HEALTH HISTORY: Please check the symptoms that seem to best describe you now.

Depression

❑ *Sad/tearful*
❑ *Irritability*
❑ *Fatigue*
❑ *Worthlessness*
❑ *Withdrawal*
❑ *Hopelessness*
❑ *Insomnia*
❑ *Difficulty concentrating*
❑ *Memory loss*
❑ *Difficulty making decisions*

Anxiety

❑ *Worry*
❑ *Muscle Tension*
❑ *Sweating/nausea*
❑ *Feeling of choking*
❑ *Chest pain or tension*
❑ *Dizziness*
❑ *Hot/cold flashes*
❑ *Apprehension*
❑ *Tingling*
❑ *Numbness*

Mania

❑ *Excessively talkative*
❑ *Grandiosity*
❑ *Racing thoughts*
❑ *Decreased need for sleep*
❑ *Theatrical or flamboyant*
❑ *Risk taking behaviors*
❑ *Pleasure seeking*
❑ *Indiscretions*
❑ *Poor decision making*
❑ *Unrestrained spending*

Fears/Phobias

❑ *Abandonment*
❑ *Being alone*
❑ *Blood/death*
❑ *Crowds/strangers*
❑ *Leaving home*
❑ *People Staring*
❑ *Elevators*
❑ *Enclosed spaces*
❑ *Heights*
❑ *Failure*

Trauma

❑ *Traumatic event*
❑ *Flashbacks/nightmares*
❑ *Intrusive thoughts*
❑ *Intrusive memories/images*
❑ *Difficulty sleeping*
❑ *Sense of doom*
❑ *Hypervigilance*
❑ *Startle easily*
❑ *Reactive to triggers*

Obsessions

❑ *Recurrent/persistent thoughts*
❑ *Thoughts dominate time*
❑ *Thoughts interfere with normal routine*
❑ *Thoughts can=t be turned off*
❑ *Attempts to neutralize thoughts are not always successful*
❑ *Thoughts feel excessive and unreasonable*

Compulsions

❑ *Feel driven to perform behaviors to reduce distress or tension*
❑ *Perfectionism*
❑ *Checking/Counting*
❑ *Washing/Touching*
❑ *Repeating certain rituals*
❑ *Putting things in order*
❑ *Making things symmetrical*
❑ *Repeating certain words*

Addictions

❑ *Difficulty limiting the pursuit or use of behavior/substance*
❑ *Internet/sex*
❑ *Gambling*
❑ *Television*
❑ *Shopping*
❑ *Computer*
❑ *Nicotine/Caffeine*

Impulse Control

❑ *Aggression toward people*
❑ *Hyperactivity*
❑ *Irritability/Arguing*
❑ *Loss of temper/raging*
❑ *Bullying, threatening others*
❑ *Stealing or lying*
❑ *Physical/mental cruelty*
❑ *Blaming others*

Cognitive Dysfunction

❑ *Inattention/Distractibility*
❑ *Delusions (False ideas)*
❑ *Hallucinations*
❑ *Paranoia/Suspiciousness*
❑ *Cognitive confusion*
❑ *Dissociations*
❑ *Loss of time/blank outs*
❑ *Poor problem solving*

Personality Issues

❑ *Suspiciousness*
❑ *Low self esteem/inferiority*
❑ *See others as attacking you*
❑ *Co-dependency/Emptiness*
❑ *Fearful of abandonment*
❑ *Difficulty making decisions*
❑ *Unstable/volatile relationships*
❑ *Mood swings/unclear goals*

Other Issues

❑ *Over/Under weight*
❑ *Binging/Purging*
❑ *Skipping meals*
❑ *Divorce/Separation*
❑ *Grieving/mourning*
❑ *Custody of Children*
❑ *School/Career Concern*
❑ *Childhood Abuse*

Have you attempted suicide or thought about it? ❑ *Yes* ❑ *No* ❑ *Thoughts* *Dates:* ______________________

Have you been hospitalized for attempted suicide? ❑ *Yes* ❑ *No* *When?* ____________ *Where?* ____________

Have you been hospitalized for psychiatric reasons? ❑ *Yes* ❑ *No* *Dates:* ______________________________

Have you been in treatment previously? ❑ *Yes* ❑ *No* *Dates:* ____________________________________

Name and location of previous therapists: ____

____

Would you like us to obtain those records? ❑ *Yes* ❑ *No* *Please provide the addresses or phone numbers:*__________

____

Has your previous therapy been helpful? ❑ *Yes* ❑ *No* *Why or why not, do you think?* ____________________

Have you had any negative experiences with previous therapists? ❑ *Yes* ❑ *No* *Please describe.* ______________

____

SUBSTANCE ABUSE HISTORY: *Think about any and all chemicals you have used, & indicate how much you used & how often, then indicate the effects/consequences it had in your life (mental, physical, family, legal, etc.). Also, for each chemical, identify what caused you to stop. A=didn't stop B=money ran out C=by choice D=family E=treatment*

Substance Used	***Age Began***	***Last Use***	***Over the last 30 days*** ***Amount/how often***	***Effects/Consequences***	***Why did you stop? When?***
Alcohol *(beer, wine, liquor)*	________	_____	________________	______________________________	__________
Cannabis *(marijuana, hashish, THC)*	________	_____	________________	______________________________	__________
Cocaine *(Coke, freebase, crack, speedball, etc.)*	________	_____	________________	______________________________	__________
Prescription Meds *(downers, librium, valium, xanax, quaaludes, halcion, seconal, etc.)*	________	_____	________________	______________________________	__________
Hallucinogens *(LSD, STP, PCP, etc.)*	________	_____	________________	______________________________	__________
Opiates *(Opium, methadone, demerol, codeine, morphine, heroine, etc.)*	________	_____	________________	______________________________	__________
Stimulants *(amphetamines, methamphetamine, speed, crystal, crank, Ritalin, etc.)*	________	_____	________________	______________________________	__________
Inhalants:	________	_____	________________	______________________________	__________
Caffeine:	________	_____	________________	______________________________	__________
Nicotine:	________	_____	________________	______________________________	__________

What are, or were, your sources of money for buying the chemicals you have used? ______________________________
____

Did using substances ever become such a problem for you that you experienced:

- ❑ *Loss of a job*
- ❑ *Public intoxication*
- ❑ *Shakes or tremors*
- ❑ *Driving a vehicle while intoxicated*
- ❑ *Memory loss due to intoxication*
- ❑ *Family fighting due to substance use*
- ❑ *Promises to quit that are not kept*
- ❑ *Quitting for a while then beginning again*
- ❑ *Lack of interest in other activities*
- ❑ *Buying, selling, trading, growing - illegal drugs (explain)* ____
- ❑ *Missed work days*
- ❑ *Drinking while at work*
- ❑ *Black outs or passing out*
- ❑ *Arrested for DUI*
- ❑ *Withdrawals or cravings*
- ❑ *Overdoses*
- ❑ *Tolerance* (could not get high no matter how much used
- ❑ *Detox episodes*

Are you currently participating in a 12 step program? ❑ *Yes* ❑ *No* *How often do you go?*________________________
Describe how you view your alcohol use. Would you say you are: ❑ *a social drinker* ❑ *heavy drinker* ❑ *an alcoholic*
Describe how you view your drug use. Are you: ❑ *a recreational drug user* ❑ *have a problem?* ❑ *have an addiction?*

FAMILY HISTORY OF SUBSTANCE ABUSE AND MENTAL HEALTH: *Please check all that apply and indicate the family member affected.*

❑ *Subst. Abuse* ____________________ ❑ *Alcohol Abuse*_________________ ❑ *Depression* ____________________
❑ *Suicide* _________________ ❑ *Anxiety* ______________________ ❑ *Bi-polar Disorder* ________________________
❑ *Psychosis* _______________ ❑ *Dementia* __________________ ❑ *Abusive* _________________________________

How much do you think your parents' problems contributed to your problems? ❑ None ❑ Some ❑ Great Deal ❑ all of it
Do you currently have a relationship with your parents and/or family of origin? ❑ *Yes* ❑ *No* ❑ *Varies*
How would you describe your family? happy/unhappy close/distant nurturing/abusive involved/neglectful
Describe yourself as a teenager: ❑ *out-going* ❑ *reserved* ❑ *respectful* ❑ *disobedient* ❑ *cooperative*
❑ *aggressive* ❑ *depressed* ❑ *isolated* ❑ *suicidal* ❑ *fearful* ❑ *bullied* ❑ *happy* ❑ *angry* ❑ *active*

FAMILY HISTORY CONTINUED . . . .

Are your parents: (MOTHER) ❑ Living ❑ Deceased (FATHER) ❑ Living ❑ Deceased

If your parents are still living are they: ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Mother's education: __________________________________ Occupation: _____________________________________

Please describe your relationship with your Mother: ____

____

Father's Education: __________________________________ Occupation: _____________________________________

Please describe your relationship with your Father: ____

____

Please describe your relationships with Step Parents, if applicable: ____

____

SIBLINGS (FULL AND STEP - please identify by F for Full and S for Step):

Name	Age	Gender	Occupation	Location	Kind of Relationship
______________________________	_____	_________	___________	_______________	❑ good ❑ poor ❑ none
______________________________	_____	_________	___________	_______________	❑ good ❑ poor ❑ none
______________________________	_____	_________	___________	_______________	❑ good ❑ poor ❑ none
______________________________	_____	_________	___________	_______________	❑ good ❑ poor ❑ none

Did you experience any of the following during your childhood?

Abandonment: By Mother ❑ Yes ❑ No By Father ❑ Yes ❑ No

Early death of a parent: Mother ❑ Yes ❑ No Father ❑ Yes ❑ No

Parental Abuse: Mental ❑ Yes ❑ No Physical ❑ Yes ❑ No Sexual ❑ Yes ❑ No Verbal ❑ Yes ❑ No Emotional ❑ Yes ❑ No

Who was the abuser? ______________________________________ How long did it go on? ________________________

Who was the abuser? ______________________________________ How long did it go on? ________________________

Were you exposed to: Trauma ❑ Yes ❑ No Domestic Violence ❑ Yes ❑ No Public Violence ❑ Yes ❑ No

Growing up did you live in homes other than your parents? ❑ Yes ❑ No Who did you live with? _____________________

Medical problems as a child: Developmental problems ❑ Yes ❑ No Serious illness ❑ Yes ❑ No Serious injury ❑ Yes ❑ No

Other problems: Achievement ❑ Yes ❑ No Behavioral ❑ Yes ❑ No Discipline ❑ Yes ❑ No

Check any of the following problems you might have had: ❑ Night terrors ❑ Bedwetting ❑ Thumb sucking ❑ Nail biting
❑ Aggression ❑ Stammering ❑ Sleepwalking ❑ Hyperactivity ❑ Distractibility ❑ Fire setting ❑ Severe shyness

ACADEMIC HISTORY:

What is the highest grade you completed? ________ GPA? ______ College? ❑ Yes ❑ No Major? _____________________

Did you like school? ❑ Yes ❑ No Were you a good student? ❑ Yes ❑ No Did you earn a degree? ❑ Yes ❑ No Year? ______

What was your degree in? ___________________________________

MILITARY HISTORY:

Have you been in the military? ❑ Yes ❑ No What branch? ________________ From when to when? ________________

Were you assigned to combat duty? ❑ Yes ❑ No Where? ____________________________ For how long? ___________

What was the nature of your duties? ____

Were you injured? ❑ Yes ❑ No Please describe: _____________________________ Diagnosed with PTSD? ❑ Yes ❑ No

LEGAL/LAW ENFORCEMENT HISTORY:

Have you been arrested, charged, or convicted of a crime? ❑ Yes ❑ No Please describe: __________________________

Are you currently being represented by an attorney for a legal problem? ❑ Yes ❑ No Describe ______________________

Is this related in any way to your treatment? ❑ Yes ❑ No How? ____

Name of Attorney or firm: ____

Thank you for completing this questionnaire. We will review it during your first session.

Signature: ____ Date: _________________________