



21000 Rogers Drive, Suite 100
 Rogers, MN 55374
 763/424-1888

PERSONAL HISTORY FORM

Client name: _____ Age: _____ D.O.B. _____ Gender: M F

Primary reason(s) for seeking services:

- Depression Anxiety Alcohol/drugs Anger management
 Coping Fear/phobias Behavior problems Martial issues/conflict
 Other _____

Please circle behaviors and symptoms that are problematic:

- | | | | |
|-------------------|--------------------|---------------------|-----------------------|
| Aggression | Worrying | Hallucinations | Attention Deficit |
| Anxiety | Heart Palpitations | People avoidant | Trouble concentrating |
| Depression | Recurring thoughts | Disorientation | Sexual problems |
| Alcohol problems | Irritability | Cyber addiction | Antisocial behavior |
| Fatigue/Tired | Impulsivity | Speech problems | Sleep problems |
| Panic attacks | Distractibility | Gambling problems | Fears/phobias |
| Anger | Chest pain | Sick often | Self injury/behavior |
| Hopelessness | Loneliness | Alcohol/Drug issues | Memory problems |
| Suicidal thoughts | Mood swings | Eating issues | Withdrawing/isolating |

Do you feel suicidal at this time? Yes or No Do you have a plan if you are suicidal? Yes or No

Briefly describe how the symptoms impair your ability to function effectively. _____

Please include any additional information that would assist us in understanding your concerns and problems?

Have you recently experienced any that follow?

- | | | |
|-------------------------------------|-------------------------------|----------------------------------|
| Recent death or birth in the family | Accident, fire, disaster | Separation or divorce |
| Job loss or change | Arrest or DUI | Major Financial problems |
| Change in living arrangements | Physical/emotional abuse | Sexual abuse or assault |
| Thoughts/acts of violence to others | Thoughts/acts of hurting self | Custody issues |
| Pregnancy, miscarriage, abortion | Diagnosis of major illness | Significant relationship discord |

Parental Information (circle)

Parents legally married Parents never married Parents divorced at what age (years)

Special circumstances (e.g., raised by person other than parents, information about spouse/kids not living with you etc.): _____

Marital status (circle):

Single _____ Years living together _____ Years legally married _____ Years widowed _____
Divorcing _____ Months separated _____ Years divorced _____ Number of marriages _____
Assessment of current relationship: good fair poor abusive

Developmental history

Has there been a history of child abuse? Yes or No If yes, which type: ___ Sexual ___ Physical ___ Verbal
Other childhood issues: ___ Neglect ___ Exposure to trauma ___ Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain _____

Social Relationships

Circle how you generally get along with other people:

Affectionate Aggressive Avoidant fight/argue often Follower
Friendly Leader Outgoing Shy/withdrawn Submissive
What is your sexual orientation? _____

Have you experienced any Sexual dysfunctions? Yes or No

Spiritual/Religious

Are you connected with a spiritual or religious group? Please explain _____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Are you involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges _____
Are you currently on probation or parole? Yes or No
Have you been accusations of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education: Currently enrolled in school High school grad/GED Vocational school
Some College College Graduate Masters or Doctorate
Any learning disabilities: Yes or No If yes, please explain _____

Employment: Current employer _____

Fulltime Part time Temp Laid-off Disabled Retired Social Security
Job satisfaction: poor good fair great

Military experience? Yes or No Combat experience? Yes or No
Where: _____ Branch: _____ Type of discharge _____ Service length _____

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 sports, etc.)

Medical/Physical Health

Primary care Doctor _____ phone _____

List any current health conditions you have and any recent health changes: _____

Are you currently using any prescribed medications: _____

Please circle if there have been any changes in the following:

Sleep patterns Eating patterns Behavior Energy level Physical activity level

General disposition Weight Nervousness/tension

Others: _____

Chemical use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hrs	Used in last 30days
Alcohol	_____	_____	_____	_____	yes	yes
Cocaine/Crack	_____	_____	_____	_____	yes	yes
Meth	_____	_____	_____	_____	yes	yes
Marijuana	_____	_____	_____	_____	yes	yes
Valium/Librium	_____	_____	_____	_____	yes	yes
Heroin/Opiates	_____	_____	_____	_____	yes	yes
PCP/LSD/Mescaline	_____	_____	_____	_____	yes	yes
Inhalants	_____	_____	_____	_____	yes	yes
Caffeine	_____	_____	_____	_____	yes	yes
Nicotine	_____	_____	_____	_____	yes	yes
Pain killers	_____	_____	_____	_____	yes	yes

Drug of choice

How does your use affect your life? _____

Has anyone expressed concern about your use? Yes or No

Are you concerned about your use? Yes or No

Is there presently or past history of a family member having problems with drugs or alcohol? Yes or No

Consequences experienced because of your use? Legal, relational, physical, mental, job, financial

Please explain: _____

Counseling Prior treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____

Is there a family history of mental illness or substance abuse problems? _____

Please list treatment goals wished to accomplish.

GENOGRAM

	NAME	AGE	YEARS Deceased	Quality of relationships now			Living w/ you
				Good	Fair	Poor	
Father							
Mother							
Step-parent							
Step-parent							
Sibling							
Grandparent							
Other							

Thank you for your time completing the questionnaire.