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PERSONAL HISTORY- ADULT

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of Birth: _____ Age: _____

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

Primary reason(s) for seeking services:

- Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Family Conflict Noncompliance
 Sleeping problems Obsessive/Compulsive behaviors Alcohol/drugs
 Hyperactivity Work Problems Social Problems Trauma
 Other concerns (specify): _____

Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____
Spouse	_____	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

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

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Marital Status (more than one answer may apply)

- Single
- Divorce in process
Length of time: _____
- Unmarried, living together
Length of time: _____
- Legally married
Length of time: _____
- Separated
Length of time: _____
- Divorced
Length of time: _____
- Widowed
Length of time: _____
- Annulment
Length of time: _____
- Total number of marriages: ____

Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

Parental Information

- Parents legally married
- Parents have ever been separated
- Parents ever divorced
- Mother remarried: Number of times: ____
- Father remarried: Number of times: ____
- Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Family Health & Mental Health History

Have any of the following diseases occurred among your blood relatives? (parents, siblings, aunts, uncles or grandparents) Check those which apply:

- Depression
- Anxiety
- Autism/Other PDD
- ADHD
- Schizophrenia
- Bipolar Disorder
- Migraines
- Muscular Dystrophy
- Seizures
- Suicide
- Mental Retardation
- Other (specify): _____
- Cancer
- Stomach Problems
- Other (specify): _____

Comments re: Family Health/Mental Health _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? __ Yes __ No

If Yes, please describe: _____

Has there been a history of child abuse? __ Yes __ No

If Yes, which type(s)? __ Sexual __ Physical __ Verbal

If Yes, the abuse was as a: __ Victim __ Perpetrator

Other childhood issues: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

- Affectionate
- Aggressive
- Avoidant
- Fight/argue often
- Follower
- Friendly
- Leader
- Outgoing
- Shy/withdrawn
- Submissive
- Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? __ Yes __ No

If Yes, describe: _____

Any recent or past history of being a sexual perpetrator? __ Yes __ No

If Yes, describe: _____

Health History

List any current health concerns: _____

List any recent health or physical changes: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? Yes No

If Yes, describe: _____

Family history of medical problems: _____

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

	Method of use and amount	Frequency of use and amount	Age of first use	Age of last use	Used in last 48 hours (circle one)	Used in last 30 days (circle one)		
Alcohol	_____	_____	_____	_____	Yes No	Yes No		
Barbiturates	_____	_____	_____	_____	Yes No	Yes No		
Valium/Librium	_____	_____	_____	_____	Yes No	Yes No		
Cocaine/Crack	_____	_____	_____	_____	Yes No	Yes No		
Heroin/Opiates	_____	_____	_____	_____	Yes No	Yes No		
Marijuana	_____	_____	_____	_____	Yes No	Yes No		
PCP/LSD/Mescaline	_____	_____	_____	_____	Yes No	Yes No		
Inhalants	_____	_____	_____	_____	Yes No	Yes No		
Caffeine	_____	_____	_____	_____	Yes No	Yes No		
Nicotine	_____	_____	_____	_____	Yes No	Yes No		
Over the counter	_____	_____	_____	_____	Yes No	Yes No		

Prescription drugs _____ Yes No Yes No
 Other drugs _____ Yes No Yes No

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): _____

Reason(s) for use:
 ___ Addicted ___ Build confidence ___ Escape ___ Self-medication
 ___ Socialization ___ Taste ___ Other (specify): _____

How do you believe your substance use affects your life? _____

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

Does/Has someone in your family present/past have/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): _____

Does your body temperature change when you drink? ___ Yes ___ No
 If Yes, describe: _____

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	Your reaction to overall experience
Counseling	_____	_____	_____	_____	_____
Psychiatric Treatment	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Self-help groups (e.g., AA, NA, Al-Anon, etc.)	_____	_____	_____	_____	_____

Have you ever been suicidal? If so, when? _____

Please check behaviors and symptoms that occur more often than you would like:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms affect your life: _____

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 Therapist's Use Only

Reviewed by:	Date:
Therapist's signature/credentials:	