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Personal History Form

Briefly describe the reason for this appointment:

Please list any **internal stressors** (sleep problems, depressive thoughts, memory problems, anxiety symptoms, eating problems, etc.) or **external stressors** (financial hardship, work/school stress, trauma, legal problems, divorce, etc.) you might be experiencing:

Internal Stressors:

External Stressors:

Please list goals or expectations that you have for therapy:

Previous Therapy

Have you ever seen a mental health provider?
_____ No.
_____ Yes. If yes, please provide the following information:

Provider	Approximate Dates	Duration	Reason

Are you currently taking or have you ever been prescribed medication for a mental health condition?
_____ No.
_____ Yes. If yes, please provide the following information:

Name of Medication	Dates Taken	Dosage	Prescribing Physician	Reason

Do you have any significant mental health problems in your family history?

___ No.
___ Yes. If yes, please describe:

_____

_____

Substance Use/History

Do you smoke tobacco?

___ No.
___ Yes. If yes, please list the amount/frequency:_____

Please list the amounts and types of beverages with caffeine that you consume on a daily basis:

_____

How much alcohol do you drink in a typical week**?**_____

Do you use any other substances?

____ No.
____ Yes. _____

Have you used any types of drugs or alcohol in the past? _____

_____

Does anyone in your family have any problems with alcohol or drugs?

____ No.

____ Yes. If yes, please describe:_____

_____

Relationship History

What is your current relationship status?

Single How long? _____

Married How long? _____

Separated How long? _____

Divorced How long? _____

Living with a partner How long? _____

Please list the names, ages and gender of all individuals living in the home.

Name	Age	Gender	Relationship to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Health History

Do you have any ongoing medical or physical problems?

_____ No.

_____ Yes. If yes, please describe:_____

_____

_____

_____

_____

Please list any other medications (not listed in previous section) that you are currently taking:

Name of Medication	Dosage	Prescribing Physician	Reason

What kind of work do you do and/or where do you attend school?_____

_____

Do you work full-time or part time? _____

Please indicate your level of education below:

_____ Grade (fill in grade)
_____ Some High School
_____ High School or Equivalent
_____ Vocation/Technical
_____ Associates Degree
_____ College – 1 year or less
_____ College – 1 year or more
_____ College Degree
_____ Graduate Degree