BUILDING LIFELONG STRATEGIES FOR CHILDREN, TEENS & ADULTS

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Personal Information Form – Adult

All information provided will remain confidential. If you are uncomfortable providing any information, please discuss with your therapist in person.

First Session Date:______________

Personal Information:

First Name:________________________ Last Name:________________________ Middle Initial:________

Nickname:_________________________ Date of Birth:_____________ Age:_______ Sex: M F G L B T

Address:____

City:_____________________________ State:________________ Zip Code:________________________

Phone:___________________________________ Is it safe to leave a message? Y N

Email address:____

In case of emergency, please notify: ____

Marital Status: Single Married Partnered Divorced Separated Widow

How long_______________ If married/partnered, spouse/partner's name:_________________________

Is your spouse/partner supportive of you seeking counseling?_____________________________________

Previous marriage(s)? Y N If yes, date of divorce(s)____

Religion:_________________________________

Do you have any children? Y N Provide names and ages as well as any comments:

Name	Age	Comment
________________________	______	____
________________________	______	____
________________________	______	____
________________________	______	____

What is your birth order? ___________of ____________ children.

Who primarily raised you?____

How would you describe your childhood?

Fantastic Loving Positive Traumatic Painful Uneventful Encouraging Supportive

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What is your favorite childhood memory(s)?

____

____

____

Were there any traumatic events during your childhood?

____

____

____

Have you ever been the recipient of unwanted sexual contact? Y N

Who were you closest to during your childhood? ______________________________

Referred by:______________________ May I thank this person for the referral? Y N

Work History:

Are you presently employed? Y N Occupation:______________________________

Employer: __________________ Hrs. / Wk. ________ How long at this job? __________

Do you have any other jobs? ______________________________________

Do you enjoy your present work? Y N Please describe ___________________________

What was the best job you ever had and why? ______________________________

____

Is your current living arrangement Satisfactory or Unsatisfactory? ____________________

____

Who do you go to for support? Parent(s) Spouse Siblings Employer Church Friends Neighbor
Other: ____

What are your hobbies or leisure activities: ______________________________

Medical History:

Are you currently under medical care? Y N (If yes, please indicate reason and provider)____________

____

How would you rate your present health? Excellent Good Fair Poor

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List any medications (prescribed, over the counter or herbal supplements you currently take):

____
____
____
____

Other significant medical history: ______________________________
____
____
____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? Y N

Name:________________________ Date from __________ to ____________

Primary reason for treatment ______________________________________

When was your last appointment? ___________________________________

Do you think the time spent was beneficial/helpful? Y N Please describe ______________

____

Have you ever attempted suicide? Y N Does anyone in your family have a history of suicide? Y N

Are you presently suicidal or homicidal? Y N

Have you ever inflicted burns or wounds upon yourself? Y N

Have you ever been the victim of abuse? Sexual Verbal Neglect Emotional Physical

Have you ever been violent toward others? Y N

List any admissions to the hospital for mental health or addiction issues:

Place of treatment: _________________________________ Date: ____________

Place of treatment: _________________________________ Date: ____________

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Substance Abuse History:

List your current usage (or usage in the past year). Include alcohol, tobacco, caffeine and non-prescription drug usage.

Substance	Amount	Frequency	Age of first use	Do you want to stop
________	________	________	________	Y N
________	________	________	________	Y N
________	________	________	________	Y N
________	________	________	________	Y N

Has there been an increase in the use of alcohol/substance within the past year? Y N

Do you, your friends or any family member see your current use as a problem? Y N

If yes, when would you say it became problematic? ________________________________

Are there any members of your family that have a history of substance abuse? ________________
____

Legal History:

List any past and current legal issues (including involvement with law enforcement; arrests; charges filed; anticipated litigation; restraining orders pending or in the past): ________________________
____
____

Is the reason for coming to therapy due to a court order? Y N

Are you currently involved with or do you foresee being involved with child custody determinations? Y N

Do you have any other legal involvements I should know about? ________________________
____

Nutrition and Weight Management:

Have you noticed a change in your eating habits recently? Y N

Has your weight changed more than +/- 10 pounds over the past year? Y N

Do you find yourself eating due to stress, depression, anger, boredom? Y N

Have you taken any diet medication, laxatives or diuretics (water pills) to control your weight? Y N

Are you happy with your present weight? Y N

Are you happy with your present physical well-being? Y N

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Describe a time when you felt fully alive: ______________________________

____

____

____

Additional:

In your own words, why are you seeking counseling at this time: ______________________________

____

____

How long have these concerns been causing you distress? ______________________________

What would you say are some of your personal strengths and weaknesses?

Strengths	Weaknesses

Anything else you want to share?

Please remember that all information will be kept confidential