



## Adult Personal History

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Form completed by (if someone other than client): \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Is it okay to contact you on your cell phone: Yes \_\_\_\_\_ No \_\_\_\_\_  
 May we leave messages? Yes \_\_\_\_\_ No \_\_\_\_\_ Which number would you prefer we leave messages?  
 \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 May we contact you via email for appointment reminders, appointment setting, or cancellation confirmation? Yes \_\_\_\_\_ No \_\_\_\_\_

**Primary Reason(s) for Seeking Services (please circle all that apply).**

Anger Management	Anxiety	Coping	Depression
Eating Disorder	Fear/phobias	Mental Confusion	Sexual Concerns
Sleeping Problems	Addictive Behaviors	Alcohol/drugs	Other (describe below)

**Family Information**

Relationship	Name	Age	Still Living	Deceased	Lives w/You	Does Not Live with You
Mother						
Father						
Spouse						
Children						

**Significant Others (e.g. siblings, grandparents, step-relatives, half-relatives. Please specify relationship).**

Relationship	Name	Age	Still Living	Deceased	Lives w/You	Does Not Live with You

**Marital Status (more than one answer may apply).**

Single \_\_\_\_\_ Divorce in Process \_\_\_\_\_ Unmarried, living together \_\_\_\_\_  
Length of Time \_\_\_\_\_ Length of Time \_\_\_\_\_  
Legally Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_  
Length of Time \_\_\_\_\_ Length of Time \_\_\_\_\_ Length of Time \_\_\_\_\_  
Widowed \_\_\_\_\_ Annulment \_\_\_\_\_  
Length of Time \_\_\_\_\_ Length of Time \_\_\_\_\_

Total Number of Marriages \_\_\_\_\_  
Assessment of Current Relationship: Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

Parental Information  
Parents Legally Married \_\_\_\_\_ Parents Divorced \_\_\_\_\_ Parents Separated \_\_\_\_  
Parents have ever been Separated \_\_\_\_\_  
Mother Remarried \_\_\_\_\_ Number of Times Mother has been married \_\_\_\_\_  
Father Remarried \_\_\_\_\_ Number of Times Father has been married \_\_\_\_\_

**Developmental & Neuropsychological History**

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/Emotional \_\_\_\_\_  
If yes, was the abuse as a victim \_\_\_\_\_ or perpetrator \_\_\_\_\_.  
Other childhood issues: Neglect \_\_\_\_\_ Inadequate Nutrition \_\_\_\_\_  
Other, please specify: \_\_\_\_\_

Have you ever had a concussion? Yes \_\_\_\_ No \_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_ Have you ever  
been partially electrocuted, partially drowned, or needed resuscitation?  
Yes \_\_\_\_ No \_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you have a history of high fevers (over 104)? Yes \_\_\_\_ No \_\_\_\_

**Social Relationship History**

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: \_\_\_\_\_

Sexual Dysfunctions: Yes \_\_\_\_ No \_\_\_\_

If Yes, please describe \_\_\_\_\_

Any current allegations or history of being a sexual perpetrator? Yes \_\_\_\_ No \_\_\_\_

If Yes, please describe: \_\_\_\_\_

**Cultural/Ethnic History**

To which cultural or ethnic group, if any, do you belong? \_\_\_\_\_

Are you experiencing any problems due to cultural or ethnic issues? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please describe: \_\_\_\_\_

Other cultural or ethnic information: \_\_\_\_\_

**Spiritual/Religious History**

How important to you are spiritual matters? Not\_\_\_\_ Some\_\_\_\_ Moderate\_\_\_\_ Very \_\_\_\_\_

Are you affiliated with a spiritual or religious group? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please describe: \_\_\_\_\_

Were you raised within a spiritual or religious group? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please describe: \_\_\_\_\_

Would you like your spiritual/religious beliefs incorporated into the counseling process?

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, please describe: \_\_\_\_\_

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**Legal History**

**Current Status**

Are you involved in any active cases (traffic, criminal, civil)? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, please describe and indicate the court and hearing/trial dates and charges

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Are you presently on probation or parole? Yes \_\_\_\_ No \_\_\_\_\_

If yes, please describe \_\_\_\_\_

**Past History**

Traffic Violations Yes \_\_\_\_ No \_\_\_\_\_      DWI, DUI, etc Yes \_\_\_\_\_ No \_\_\_\_\_

Criminal Involvement Yes \_\_\_\_ No \_\_\_\_\_      Civil Involvement Yes \_\_\_\_\_ No \_\_\_\_\_

If you responded Yes to any of the previous relating to Legal History, please fill in the following information.

Charges	Date	Where (City)	Results

**Education History**

Fill in all that apply: Years of Education \_\_\_\_\_ Currently enrolled Yes \_\_\_\_ No \_\_\_\_

High School graduate/GED \_\_\_\_\_

College: \_\_\_\_\_ Number of Years \_\_\_\_ Graduated Yes \_\_\_\_ No \_\_\_\_ Major \_\_\_\_\_

Graduate: \_\_\_\_\_ Number of Years \_\_\_\_ Graduated Yes \_\_\_\_ No \_\_\_\_ Major \_\_\_\_\_

Other training: \_\_\_\_\_

Learning Disabilities? Yes \_\_\_\_ No \_\_\_\_\_

Special Education Courses? Yes \_\_\_\_\_ No \_\_\_\_\_

What subjects do you or did you prefer in school? \_\_\_\_\_

What subjects do you or did you dislike in school? \_\_\_\_\_

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**Employment History**

(Begin with most recent job)

Employer	Dates	Title	Reason left the job	How often did you miss work?

**Alcohol/Substance Abuse History**

	Method of use & amount	Frequency of use	Age of first use	Age of last use	Used in the last 48 hours Yes	Used in the last 48 hours No	Used in the last 30 days Yes	Used in the last 30 days No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin/Opiates								
Marijuana								
PCP/LSD/Mescaline								
Methamphetamines								
Inhalants								
Caffeine								
Nicotine								
Over the Counter								
Prescription Drugs								
Other								

Substance of Preference 1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 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 (Circle all that apply)

- Addicted      Build Confidence      EscapeSelf Medication      Socialization  
 Taste      Other (specify): \_\_\_\_\_

How do you believe your substance use affects your life? \_\_\_\_\_

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

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Does/Has someone in your family present or past have or had a problem with drugs or alcohol? Yes \_\_\_\_\_

No \_\_\_\_\_ If Yes, please describe: \_\_\_\_\_

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Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes \_\_\_\_\_

No \_\_\_\_\_ If Yes, please describe: \_\_\_\_\_

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Have you had adverse reactions or overdose to drugs or alcohol? (describe)

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