Counseling Connections for Change, Inc.
Mental Health Matters!

"To put Christian principles into programs that build healthy individuals, families and community."

ADULT PERSONAL HISTORY FORM

Please complete this form to the best of your knowledge. Please write N/A for questions that are not applicable to you. If you need more space or wish to make additional comments, please attach a separate sheet of paper. All information is confidential. Please know that by providing these details I will gain a better understanding of you and be better equipped to assist you.

I. DEMOGRAPHIC INFORMATION

Demographic information is collected by Counseling Connections as a tool to measure outcomes and improve service provision. This information may be shared with funding partners, but at no point would your personal information; i.e., name, address, contact information, or date of birth be used.

Client's Name ____
Therapist Name ____ **Today's date** _____________
Gender ___**M** ___**F** **Date of Birth** _______ **Your Age today** ________
Ethnicity/Race (circle the one you identify with most):
Caucasian African-American Hispanic Native-American Asian-American/Pacific Islander Other
Address ______________________ **City** ___________________ **County** _________ **State** _____ **Zip** _________
Phone (Home) ___________________ **(Work)** _____________________ **(Cell)** __________________
How were you referred to our office? _____________________________ **How will your services be paid?**
___ **Sliding Scale (all cash clients complete this process)** __ **Insurance (list the name)** ____________________
How would you classify your Employment Status:
__ **Wage Earner** ___**Unemployed** ___ **Public Assistance** ___ **Retired**
___**Student** ___ **College Student** ___**Homemaker** ___ **Social Security**

What is the best way to contact you? ____
Is it okay to contact you at home? ____

II. PRESENTING PROBLEMS

What prompted you to seek treatment? ____
____
How would you scale you're your quality of life today? 1----------------------5-----------------------10
How would you scale you're your quality of life 1 month ago, 1----------------------5-----------------------10?
What is your hope for your future quality of life? 1----------------------5-----------------------10 How would you rate the severity of your symptoms today? __Mild __Moderate __Serious __Severe
How would you rate the severity of your symptoms 1 month ago? __Mild __Moderate __Serious __Severe

What specific symptoms/problems do you think are relevant to your treatment? Please check all that apply.

__ Aggressive behaviors
__ Angry outbursts
__ Crying easily
__ Trouble concentrating
__ Recent weight change
__ Fears/phobias
__ Coping problems
__ Legal problems

__ Fatigue or loss of energy
__ Depressed mood
__ Feelings of worthlessness
__ Thoughts of hurting yourself or others
__ Nightmares
__ Sleep disturbances
__ Relationship problems (peers or family)
__ Financial stress
__ Academic problems
__ Odd behaviors or thoughts
__ Taking alcohol/drugs
__ Difficulty following directions
__ Abusive relationships
__ Social withdrawal
__ Distrust
__ Rapid heart rate
__ Restlessness
__ Recent traumatic events
__ Unresolved childhood issues
__ Chest pains
__ Increased illnesses or medical problems
__ Dizziness or lightheadedness
__ Stomach problems
__ Sweating
__ Grief or loss issues
__ Parenting problems

III. BIOPSYCHOSOCIAL

FAMILY INFORMATION

Family Information

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

Significant Others (Brothers, Sisters, 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/ (number of times)
Length of time _____/_____

_____ Widowed
Length of time _____

_____ Annulment
Length of time _____

Total number of marriages _____

How satisfied are you with your current relationship status? Please put an X to indicate your level.

Extremely Satisfied ____Completely Dissatisfied

Please describe your level of satisfaction:____

____

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, spouse/children not living with you, etc.)

____

____

____

Strengths/support ____

Stressors/problems ____

DEVELOPMENT

Did you experience any developmental problems as a child (0-18 years)?

In Utero______________ As a toddler____________________ School age___________________

Adolescence____________________ Early adulthood___________________ As an adult ____________________

Have you ever been abused as a child or an adult? _____ No _____Yes

If yes, which types of abuse? _____ Sexual _____ Physical _____ Verbal _____ Perpetrator _____Victim

If yes, was the abuse ever reported? _____ No _____Yes (describe) ____

Other childhood issues: ___ Neglect ___ Inadequate Nutrition ___ Medical Complications

How much distress do you experience today as a result of your childhood experiences? Please put an X on the line.

Extreme Distress____ No Distress

Comments regarding childhood experiences: ____

____

SOCIAL RELATIONSHIPS

Check how you generally interact with friends and family members: (check all that apply)

_____ Lovingly _____ Fight/Argue _____ Get picked on _____ Try to avoid them

Other (specify) ____

How would you describe your personality? (check all that apply)

_____ Follower _____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn

Do you have a best friend now? _____ No _____ Yes In the past? _____ No _____ Yes

Sexual Orientation: _____________________ Comments: ____

How satisfied are you with your current relationship status? Please put an X to indicate your level.

Extremely Satisfied ____Completely Dissatisfied

Please describe your level of satisfaction:____
____

Strengths/support ____
Stressors/problems ____

CULTURAL / ETHNIC

From which cultural or ethnic group, if any, do you belong? ____

Are you experiencing any problems due to cultural or ethnic issues? _____ No _____ Yes (describe) _____________
____

Other cultural / ethnic information: ____
____

Strengths/support ____
Stressors/problems ____

SPIRITUAL / RELIGIOUS

How important to you are spiritual matters? _____ Not _____ Little _____ Moderate _____ Much

Are you affiliated with a spiritual or religious group? ____

Were you raised within a spiritual or religious group? _____ No _____ Yes (describe) ________________________

Would you like your spiritual/religious beliefs incorporated into the counseling?
_____ No _____ Yes (describe)____

At this time, how close do you feel to God? Put an X on the line below.

Very Close ____Completely Disconnected

Strengths/support ____
Stressors/problems ____

LEGAL

List all arrests/charges (juvenile history and adult history) dates of arrests, time incarcerated, if it is a pending case
____
____
____

Please describe any past or present services or systems that have been involved in your life (e.g., CPS, Government support, school counseling, etc.) ____

Have either of your parents been incarcerated? ___No ___Yes (describe which one and how old you were during the incarceration period) ____

Have any other family members been incarcerated? ___No ___Yes (describe which one and how old you were during the incarceration period) ____

Strengths/support ____
Stressors/problems ____

EDUCATIONAL

Graduated from High School/GED? _____ No _____ Yes Year Completed? ___________

College: _____________ Major: _________________ Year Completed? ___________

How satisfied are you with your current level of education? Please put an X to indicate your level.

Extremely Satisfied ____Completely Dissatisfied

Strengths/support ____
Stressors/problems ____

EMPLOYMENT

Begin with most recent job, list job history:

Employer	Dates	Title	Reason Left the Job	How often miss work?

How satisfied are you with your current employment? Please put an X to indicate your level.
Extremely Satisfied ____Completely Dissatisfied

Strengths/support ____
Stressors/problems ____

MILITARY

Military Experience? _____ No _____ Yes Combat History? _____ No _____ Yes
Branch ___________________ Discharge Date _______________ Date Drafted _____________
Type of Discharge __________ Date Enlisted ________________ Rank at Discharge _____________
How much has your military experience affected your life? Please place an X on the line to indicate distress. Extreme Distress ____No Distress

Strengths/support ____
Stressors/problems ____

LEISURE / RECREATIONAL/PERSONAL SELF-CARE

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, church activities, diet/health, fishing, traveling, etc.)

____
____

How much time do you spend taking care of yourself? Put an X on the line to indicate.
I care for myself regularly ____I feel like I never care for myself

Strengths/support ____
Stressors/problems ____

MEDICAL / PHYSICAL HEALTH

Do you have any active medical problems? ___No ___Yes

If "Yes," describe: ____
List all medications you are currently taking:____
Have you ever been hospitalized? ___No ___Yes
If "Yes," describe: ____
Do you have allergies? ___No ___Yes Describe: ____
Do you currently have any medical problems that are not being treated by a doctor, but should be?
_____ No _____ Yes (describe) ____
List any 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

Describe changes marked above: ____
____
____
Name of Current Physician: ____
Last date of your physical exam: ____

CHEMICAL USE HISTORY

Have you ever used any illegal drugs? _____ No _____ Yes (list the name of the substance, i.e. marijuana, cocaine, heroin, other opiates, methamphetamine, LSD, mushrooms, ecstasy) ___ ______________________________________
____
Do you use tobacco products? ___ No ___Yes (describe frequency and amount) ______________________________
Do you drink alcohol? _____ No _____ Yes (describe frequency and amount) _______________________________
DWI/DUI? _____ No _____ Yes
Public Intox _____ No _____ Yes
Have any of your family members or significant relationships had a problem with drugs or alcohol?
_____ No _____ Yes (describe who and circumstances) ____
____
How much of a problem has alcohol or drugs been in your life? Please put an X on the line.
Extreme problem____No problem

COUNSELING / PRIOR TREATMENT HISTORY

Have you ever participated in any counseling/therapy services? _____ No _____ Yes (describe when/where)
____
Has any professional ever diagnosed you for mental health issues? Describe: _________________________________

Are you currently seeing another therapist? _____ No _____ Yes If so, who? _________________________________

Have any of your family members or significant relationships been involved in counseling or treatment?
_____ No _____ Yes (describe) ____
____
Does anyone in your family have a history of mental health issues such as: (depression, anxiety, ADHD, bipolar disorder) Describe: ____

Have you ever been hospitalized for drugs/alcohol/psychiatric care? _____ No _____ Yes (when/name of treatment facility)
____
____

Have you ever been involved in any self-help groups (AA, NA, Al-Anon, etc.)? _____ No _____ Yes
Which ones? ____
Have you ever attempted suicide or had suicidal thoughts? _____ No _____ Yes (describe)
____
____
Are you feeling suicidal now? _____ No _____ Yes (describe)
____
____
Have you ever had homicidal thoughts? _____ No _____ Yes
Have you ever or do you currently engage in self injurious behavior (cutting)? _____ No _____ Yes
Any history of domestic violence? _____ No _____ Yes; Perpetrator? ____ Victim? _____ Witness? _____
Do you have access to weapons? _____ No _____ Yes

CLIENT OPINION ABOUT STRENGTHS AND NEEDS

What do you see as your/your family strengths?

____
____
____
____
____
____

Is there any other information about you that you think is relevant for your treatment planning?

____
____
____
____
____
____

Please list at least one goal you would like to reach during the course of your treatment.

____
____
____
____
____
____

____
PRINTED NAME OF PERSON COMPLETING THIS FORM

____ ____________
SIGNATURE OF PERSON COMPLETING THIS FORM DATE

____
RELATIONSHIP TO THE CLIENT (self, parent, guardian)