
PERSONAL HISTORY FORM

Name _____ Gender: M F T
(Last) (First) (Middle/Maiden)
Birth date _____ Age _____ Social Security # _____

Phone (home) _____ OK to call? Yes No OK to leave message? Yes No
Phone (work) _____ OK to call? Yes No OK to leave message? Yes No
Phone (mobile) _____ OK to call? Yes No OK to leave message? Yes No
E-mail Address: _____ OK to use? Yes No

Address _____

Note: Some individuals share voicemail or email with others and would prefer not to have messages left.

Highest Educational Level or Degree Attained _____

Occupation and Place of Employment/School _____

Referred by: _____

May I have your permission to thank this person for the referral? _____ Yes _____ No

(no additional information will be shared with this individual)

Person to contact in case of emergency:

Name _____ Relation _____

Phone (home) _____ Phone (work) _____ Phone (mobile) _____

Address _____

With whom do you live: (check all that apply)

____ Alone ____ Partner/Spouse ____ Roommate(s) ____ Parent(s) ____ Child(ren)

____ Sibling(s) ____ Friend ____ Others _____

Relationship status: (check one)

____ Single ____ Married ____ Engaged ____ Separated ____ Divorced ____ Widowed

____ Remarried (number of times _____)

Partner/Spouse's Occupation _____ Partner/Spouse's Age _____

Number of Children _____ Ages and Sex _____

Number of Step-Children _____ Ages and Sex _____

FAMILY HISTORY

Please check all those with whom you lived while growing up:

____ both biological parents ____ adoptive parents

____ mother & stepfather ____ single parent (which?) _____

____ father & stepmother ____ other relatives (which?) _____

____ other (describe) _____

Mother: Name _____ Age: _____ Occupation: _____

If deceased, how old was she? _____ How old were you? _____

Father: Name _____ Age: _____ Occupation: _____

If deceased, how old was he? _____ How old were you? _____

List age and sex of sisters and brothers: _____

HEALTH HISTORY

Previous psychotherapy, counseling, assessment, or hospitalizations:

Dates: _____

Provider (s): _____

Location (s): _____

Primary issue(s): _____

Medications: _____

Have you had a history of heavy alcohol or drug use? ____ Yes ____ No

If yes, please explain: _____

Current Medical Problems _____

Current Medications _____

Nature and date(s) of previous significant medical problems:

Name and Address of Physician _____

Have you ever attempted suicide? ____ Yes ____ No If so, at what age(s) _____

Do you feel suicidal at this time? ____ Yes ____ No

Have any of your relatives or loved ones attempted or committed suicide? ____ Yes ____ No

If yes, when & relation to you _____

Has anyone in your family been treated for a psychiatric disorder? ____ Yes ____ No

If yes, relation to you and type of treatment received: _____

Has anyone in your family had a history of heavy alcohol or drug use? ____ Yes ____ No

If yes, please explain: _____

MILITARY HISTORY

List military experience (include dates of service and type of discharge): _____

CLINICAL INFORMATION

Briefly state why you are seeking psychotherapy at this time: _____

How long have you been troubled by these issues? _____

How long do you expect therapy to last? _____

Do you consider the severity of your problem(s) to be:

____ Mild ____ Moderate ____ Severe ____ Extreme ____ Incapacitating