PERSONAL HISTORY FORM

Name: _____ Date of birth: _____ Age: _____

Address: _____

Home Phone: ( ) May I leave a message? __Yes __No
Cell/Other Phone: ( ) May I leave a message? __Yes __No
May I text? __ Yes __No

Email: _____ May I email you? __Yes __No
**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by: _____

DEMOGRAPHIC INFORMATION

What is your current gender identity? (Check ALL that apply) ☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer ☐ Additional category (please specify): _____ ☐ Decline to answer

What sex were you assigned at birth? ☐ Male ☐ Female ☐ Other ☐ Decline to answer

What pronouns do you prefer that we use when talking about you? (check all that apply)
☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other: _____
☐ Decline to answer

What is your sexual orientation/preference? (check all that apply) ☐ Straight ☐ Gay ☐ Lesbian
☐ Bisexual ☐ Pansexual ☐ Other: _____ ☐ Decline to answer

What is your marital/relationship status? (check all that apply) ☐ Single ☐ Never married
☐ Dating ☐ Domestic Partnership ☐ Engaged ☐Married ☐ Polyamorous
☐ Recent Breakup ☐ Separated ☐Separated and living together ☐ Divorced ☐Widowed
☐ Other: _____ ☐ Decline to answer

Please list any children (biological, adoptive, foster care and/or step-children) as well as their ages:

_____

_____

Is there a custody agreement? __Yes __No Please describe:

_____

_____

TREATMENT HISTORY

Have you previously received any type of mental health services or substance abuse treatment in the past or are you in treatment of any kind at present? __Yes __No

If yes, please check all that apply as well as provide the location, onset and duration of treatment:

☐ Individual therapy _____
☐ Couples/Family therapy _____
☐ Outpatient psychopharmacologic treatment _____
☐ Partial Hospital or Intensive Outpatient Program _____
☐ Psychiatric Admission _____
☐ Detox _____
☐ Residential treatment _____
☐ Other _____
☐ Decline to answer

Please provide additional details if needed about your treatment history.

_____

_____

_____

_____

If you have received mental health services in the past, how would you describe your experience? For example, was the treatment helpful, unhelpful, traumatic, neutral, etc:

_____

_____

_____

_____

_____

Are you currently taking any prescription medication for mental health? __ Yes __ No

Please list:

_____

_____

_____

Have you been prescribed psychiatric medication in the past? __Yes __No

Please list and provide dates: _____
_____
_____
_____

GENERAL HEALTH/MENTAL HEALTH INFORMATION

1.How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any medical diagnoses and/or specific health problems you are currently experiencing: _____
_____
_____

2. Do you have any allergies? __Yes __No
Please list: _____

3. Are you currently experiencing chronic pain? __Yes __No
Please describe: _____

4. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:
_____
_____

5. How many times per week do you generally exercise? _____
What types of exercise/movement do you participate in? _____

6. Please list any difficulties you experience with your appetite or eating patterns, weight or body image:
_____
_____

7. Are you currently experiencing overwhelming sadness, grief or depression?
__Yes __No If yes, how long? _____

8. Do you ever experience suicidal thoughts or feelings? __Yes __No
Do you feel suicidal presently? __Yes __No
Have you had any suicide attempts? __Yes __No
If yes to any of these questions, please describe: _____
_____
_____

9. Are you currently experiencing anxiety, panic attacks or have any phobias?
__Yes __No If yes, when did you begin experiencing this? _____

10. Do you drink alcohol more than once per week? __Yes __No

11. How often do you engage in recreational drug use?
__Daily __Weekly __Monthly __Infrequently __Never

12. Do you have a history of or current problem with substance abuse? __Yes __No
If yes, please describe: _____
_____

13. Is there a history of trauma/abuse? __Yes __No
If yes, please check all that apply:
☐ Emotional/Mental Abuse ☐ Physical Abuse/Violence ☐ Witnessing Abuse/Violence of any kind ☐ Neglect/Deprivation (both physical and/or emotional)
☐ Sexual Abuse/Assault ☐ Combat/Military ☐ Cult/Religion
☐ Medical Injury, illness or procedures ☐ Natural Disaster ☐ Accidents
☐ Traumatic Loss ☐ Racism/Prejudice/Sexism/Homophobia/Bigotry ☐ Bullying
☐ Body Shaming ☐ Do not remember ☐ Decline to Answer
☐ Other _____

14. What significant life changes or stressors have you experienced recently? _____
_____
_____
_____
_____
_____
_____
_____

FAMILY MENTAL HEALTH INFORMATION

In the section below, identify if there is a family history of the following. If yes, please indicate the relationship you have to the family member (i.e., father, grandmother, uncle, etc).

	Please Circle	Family member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Bipolar Disorder	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
OCD	yes/no	
Schizophrenia	yes/no	
Suicide attempts	yes/no	
PTSD/Trauma	yes/no	
Psychiatric Admissions	yes/no	

ADDITIONAL INFORMATION

1. Are you currently employed or are in school? __Yes __No

   If yes, what is your current employment/school situation?
   _____

   Do you enjoy your work/school? Is there anything stressful about your current work/school?
   _____
   _____

2. Are you currently in a romantic relationship? __Yes __No

   If yes, how long? _____
   On a scale of 1-10, how would you rate your relationship? _____

3. Do you consider yourself to be spiritual or religious? __Yes __No

   If yes, describe your faith or belief: _____

4. What do you or others consider to be some of your strengths?
_____

_____
_____

5. What do you consider to be some of your struggles/limitations?
_____
_____
_____

6.What are your goals for therapy? _____
_____
_____
_____