Groupworks: Tony L. Sheppard, Psy.D. CGP
Personal History Form—Adult (18+)

Client's name: ___________________________ Date: _____________

Gender: ___ F __ M Date of birth: _______ Age: _______________

Form completed by (if someone other than client): ____________________________________

Address: _______________________ City: ______________ State: _____ Zip: _________

Phone (home): ___________________ (work): _________________ ext: __________

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

__ Anger management ____ Anxiety ____ Coping ____ Depression

__ Eating disorder ____ Fear/phobias ____ Mental confusion ____ Sexual concerns

__ Sleeping problems ____ Addictive behaviors ____ Alcohol/drugs

__ Other mental health concerns (specify): ______________________________________

Family Information

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

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living Yes	Living No	Living with you Yes	Living with you No

Relationship 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
Length of time: ___________

__ Widowed
Length of time: ___________

___ Annulment
Length of time: __________

___ Domestic Partnership
Total number of marriages: ____

Assessment of current relationship (if applicable): ________ Good ___________________ Fair __________ Poor

Parental Information

__ Parents legally married ____ Mother remarried: Number of times: _

__ Parents have even been separated ____ Father remarried: Number of times: _

__ Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

Development

Are there special, unusual, or traumatic circumstances that affected your development? __ Yes ________ No

If Yes, please describe: ____

Has there been history of child abuse? _______ Yes ________________________ No

If Yes, which type(s)? _ Sexual ____ Physical ____Verbal

If Yes, the abuse was as a: __________ Victim ______ Perpetrator

Other childhood issues: ________ Neglect _____________ Inadequate nutrition___________ Other (please specify):

Comments re: childhood development: ____

____

Social Relationships

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: _______________ Comments: ________________________

Sexual dysfunctions? Yes ________ No____

If Yes, describe: ____

Any current or history of being as sexual perpetrator? ____ Yes ____No

If Yes, describe: ____

Cultural/Ethnic

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, describe: ____

Other cultural/ethnic information: ____

Spiritual/Religious

How important to you are spiritual matters? _______ Not ____ Little ______ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ______ Yes ________________________ No

If Yes, describe: ____

Were you raised within a spiritual or religious group? _______ Yes ________________________ No

If Yes, describe: ____

Would you like your spiritual/religious beliefs incorporated into the counseling? ______ Yes ____ No

If Yes, describe: ____

Legal

Current Status

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

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

____

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

Comments About Above:____

Education

Fill in all that apply:Years of education: _______Currently enrolled in school? __ Yes ___ No

__ High school grad/GED

__ Vocational: Number of years: __ Graduated: __ Yes ___ No Major: ________________

__ College: Number of years: __ Graduated: __ Yes ___ No Major: ________________

__ Graduate: Number of years: __ Graduated: __ Yes ___ No Major: ________________

Other training: ____

Special circumstances (e.g., learning disabilities, gifted): ______________________________

Employment

Begin with most recent job, list job history:

Employer	How Long	Title	Like Job?	How often miss work?
________________	____________	__________	_______________	_________________

Currently: ____ FT __ PT ___ Temp ___ Laid-off ___ Disabled __ Retired

__ Social Security __ Student ____ Other (describe): _______________________________

Military

Military experience? __ Yes ___ No Combat experience? ______ Yes ___________ No

Where: ____

Branch: ______________________________ Discharge date: _________________________

Leisure/Recreational

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

Activity	How often now?	How often in the past?
____________________________	_______________________	_______________________
____________________________	_______________________	_______________________
____________________________	_______________________	_______________________

Medical/Health

__ AIDS
__ Alcoholism
__ Abdominal pain
__ Abortion
__ Allergies
__ Anemia
__ Appendicitis
__ Arthritis
__ Asthma
__ Bronchitis
__ Bed wetting
__ Cancer
__ Chest pain
__ Chronic pain

___ Dizziness
___ Drug abuse
___ Epilepsy
___ Ear infections
___ Eating problems
___ Fainting
___ Fatigue
___ Frequent urination
___ Headaches
___ Hearing problems
___ Hepatitis
___ High blood pressure
___ Kidney problems
___ Measles

____ Nose bleeds
____ Pneumonia
____ Rheumatic Fever
____ Sexually transmitted diseases
____ Sleeping disorders
____ Sore throat
____ Scarlet Fever
____ Sinusitis
____ Small Pox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache

__ Colds/Coughs	___ Mononucleosis	____ Thyroid problems
__ Constipation	___ Mumps	____ Vision problems
__ Chicken Pox	___ Menstrual pain	____ Vomiting
__ Dental problems	___ Miscarriages	____ Whooping cough
__ Diabetes	___ Neurological disorders	____ Other (describe): _______
__ Diarrhea	___ Nausea	___________________________

List any current health concerns: ____

List any recent health or physical changes: ____

____

Nutrition

How would you describe your appetite over the past month?

____Excellent ____Good ____Fair ____Poor

Have you gained or lost any weight recently? ____Yes ____No If Yes, How much?_____________

Were you dieting? ____Yes ____No

Comments: .

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? _______ Yes _________ No

If Yes, describe: ____

____

	Date	Reason	Results
Last physical exam			
Last doctor's visit			
Last dental exam			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: ____

____

Pleases 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/tension

Describe changes in areas in which you checked above: ____

Chemical Use History

If you have a history of substance use/abuse, please complete a ***Chemical Use Survey***-available upon request.

Do you smoke cigarettes? Y N Use smokeless tobacco? Y N

How would you describe your alcohol use? Don't drink Social drinker Daily drinker Alcoholic In Recovery

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	____	____	____________	____________________	______________
Suicidal thoughts/attempts	____	_____		_____________________________	_________________
Drug/alcohol treatment	__	____	____________	___________________	_________________
Hospitalizations	____	____	____________	___________________	_________________
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	____	_____		_____________________________	_________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

__ Aggression
__ Alcohol dependence
__ Anger
__ Antisocial behavior
__ Anxiety
__ Avoiding people
__ Chest pain
__ Cyber addiction
__ Depression
__ Disorientation
__ Distractibility
__ Dizziness
__ Drug dependence
__ Eating disorder

____ Elevated mood
____ Fatigue
____ Gambling
____ Hallucinations
____ Heart palpitations
____ High blood pressure
____ Hopelessness
____ Impulsivity
____ Irritability
____ Judgment errors
____ Loneliness
____ Memory impairment
____ Mood shifts
____ Panic attacks

___ Phobias/fears
___ Recurring thoughts
___ Sexual addiction
___ Sexual difficulties
___ Sick often
___ Sleeping problems
___ Speech problems
___ Suicidal thoughts
___ Thoughts disorganized
___ Trembling
___ Withdrawing
___ Worrying
___ Other (specify): _______
____

Briefly discuss how the above symptoms impair your ability to function effectively: _____________

____

____

Any additional information that would assist us in understanding your concerns or problems: ____

____

____

____

What are your goals for therapy? ____

____

____

Do you feel suicidal at this time? ______ Yes _______ No

If Yes, explain: ____