Peace of Mind Counseling, LLC
Personal History Form

In the following form, "you" refers to the client:

Your (Client's) Name ____ Today's Date _____________

Gender F____ M____ Date of Birth ______________ Current Age ______

Form completed by (if other than client)

Relationship _________________________________

HOME ENVIRONMENT: With whom do you live?

Full Name	Age	Relationship to you

If not included above, how many siblings do you have? ______ Are your parents living? ________________________

Were you adopted? Y N At what age?________

WORK/SCHOOL: School attended, highest grade or degree achieved_________________________________

Describe any learning difficulties in elementary or high school____

Place of employment / type of job ____Schedule ______________

Do you experience difficulties at school and/or work? If so, explain_____________________________________

____

REASON FOR COUNSELING: Briefly explain your issues of concern_________________________________

____

Length of time you have had these concerns ____

How would you rate the intensity of the concern? (1=Mild, 5=Moderate, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

Describe ways you have attempted to cope ____

What would you like to see accomplished through counseling (your goals)?______________________________

____

Medical History: Any medical concerns you have ____

Any significant medical concerns in your family_

List any known allergies you have, including allergies to medication____________________________________

Your primary physician and clinic/hospital location ____

Previous Counseling: Have you ever participated in counseling services prior to this occasion? Y N

When ____ Approx.# of sessions _______________

Therapist and clinic____

Was it helpful? Y N Why or why not?____

Have you taken any medications for *mental health* symptoms? Y N

Medication _____________________ For what symptom ________________ How long ______________

_____________________ For what symptom ________________ How long ______________

_____________________ For what symptom ________________ How long ______________

Are/were you satisfied with the outcome of medication treatment? Y N

List current medications you take for *physical* symptoms ____

Legal History: List any past legal involvement, crimes you have committed ___________________________

____

Military History: Y N If yes, Branch, year(s) served, other details ________________________________

MOOD ASSESSMENT: Check if you have or are experiencing problems with any of the following:

Impaired: Concentration _______ Thinking _______ Reasoning _______ Perception _______ Memory _______

Depressive Symptoms: Negative thoughts ____ Lack of energy ______ Restlessness or Mania ______

Appetite increase ____ Appetite decrease _____ Any change in weight: Up_____lbs. or down___lbs.

Increased sleep______ Decreased sleep ______ Avg. # hrs. sleep/night _____

Suicidal Symptoms: Preoccupation with death ______ Talked about suicide or had suicidal thoughts______

Number of previous attempts ______ Specific action ___________________________________

Do you habitually cut, burn or otherwise harm yourself without intent to die? Y N Describe ______________________

____ How frequently? ___________________________________

Anxiety Symptoms:

List signs of anxiety, describe____

Name the source of the anxiety, if known____

Do you have a history of panic attack(s)? Y N

Describe what was happening at the time ____

Obsessive or Compulsive Symptoms: Y N Explain ____

____

Anger: Short temper or trouble controlling anger? Describe ____

____

Did either parent have trouble controlling anger? Y N History of domestic violence in your family? Y N

Have you had any significant consequences or legal charges due to anger/domestic violence Y N

Describe____

Alcohol or Substance Use/Abuse History: How often do you drink alcohol?______________________

Have any family members had problems with alcohol abuse? Y N Who? _____________________________

Have you ever experimented with drugs/other substances? _____ Which one(s)? _____________________

Consequences (self, family, health, legal) ____

Is anyone close to you concerned about your use of alcohol or other substances? Y N Who? ______________

Abuse History: Have you experienced any of the following types of abuse in the past or present?

Sexual abuse ______ Physical abuse ______ Emotional abuse ______ Verbal abuse ______

Describe ____

Family and Social Functioning:

Do you have close friends? ______________________________ How often spend time together? __________________

Which family member(s) are you close to? ____

Which family member(s) are you in frequent conflict with? ___________________________________

Your favorite activities or hobbies ____

Sexuality: Do you identify as GLBT? __________ Do you have any sexual concerns? __________________________

Religious Affiliation: Do you have a religious affiliation? Y N Describe __________________________________

What are your personal strengths? ____

____

What are your personal struggles or weaknesses?____

____

Thank you for filling out this form! It will help us understand you and serve you better.

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