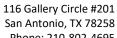




## **Adult Personal History**

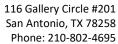
Client's Name:			Date:		
Gender:FM	Date of Birth:/_	/	Age:		
Phone (home):	(work):	(cell): _			
Okay to leave messages □Voi □Work Fmail Address		•	nfidential message	: □Home □Cell	
Relationship to client:					
Counseling I am seeking:  Primary reason(s) for seeking		Couple Therapy	Group Therap	ру	
Anger management	=	Self-Harmin	g Behaviors	Depression	
	Parenting			Fear/phobias	
Sleeping Disturbance				Hyperactivity	
	Alcohol/Drugs	Inattentiven		Gender Identity	
Marital Conflict Abuse (Physcial, Menta	ict Infidelity Grief Ch			Chronic Pain	
PROBLEM INTENSITY: How would  1 2  Not intense	3	roblem or concern that broug 4 Ioderately Intense	ght you in? (Circle the a	appropriate number):  6 Extremely Intense	
When did you first notice ons	et of the reason you are s	seeking services:			
How long has this been a pro	blem/concern:				
Have you <b>seen another therapist</b> in If yes, who did you see and how long		YesNo			
Have you been hospitalized for When?					
Describe how the onset of the	e reason you are seeking	assistance is negatively	impacting your lif	e: 	
Have you had <b>suicidal thoughts</b> red Have you had them in the past?	cently?frequently frequently _	sometimesrare sometimesrare			
Have you ever intentionally inflicted	any harm upon yourself?Y	/esNo	Uns	ure	





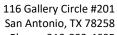
Phone: 210-802-4695

Hives	AsthmaI MeningitisI	Miscarriage	_	ncy Seizure	•			
List any current hea	uryThyroid di alth concerns:			ansmitted disease	eother			
Did you discuss you	t medical appointme ur current symptoms ults of the appointme	s:Yes						
Sleep patterns Behavior	re have been any rec Eating patterns Weight es in areas checked a	Physical General	activity lev	elEnergy		ntion level		
Medications (Pleas Currently prescribe	e list all medications d medications	•	equency	Date Started	Purpose	Side Effects  No Yes  No Yes  No Yes  No Yes  No Yes		
List any medication	allergies:					_ □No □Yes 		
	ory or have a problem v ibe alcohol and/or di		r drugs?	_NoYes				
deaths serious il psychiatr financial d	• • • • • • • • • • • • • • • • • • • •	divorce debilita physica	or impending special problems in your family) divorcedebilitating injuries/disabilitiesphysical/sexual abuseattempted/completed suicide		freque alcoho legal p	frequent relocationsalcohol/drug abuselegal problemeating disorders		
Please specify <b>family m</b>	nember(s), with special	problems, and a	pproximate ye	ear of occurrence (e.g	. mother, serious illr	ness,1998, etc.)		





Partner Status	
Date Married or Plan to be Married (if applicable):	
Have you been married before, and if so, how many times?	
How long have you and your partner been in this relationship?	
Are you and your partner presently living together? Yes No  Are you and your partner engaged, separated, or in any litigation or arbitration (please explain)?	
What would you like to accomplish out of your time in couples therapy?:	
Approximately how many <b>significant intimate relationships</b> (e.g. lasting 6 months or more) have you been involved in?  Are you in one now?YesNoI think so	
Besides family members, approximately how many people can you really count on right now for friendship or <b>emotional suppo</b>	rt?_
Cultural Background: What is your ethic identity?	
African/African AmericanAsian American/ Chinese/ Filipino/ Japanese/ Korean/ VietnameseEast Indian/PakistaniLatino/ Hispanic/ Mexican-American/ Puerto RicanMiddle EasternNative American/ Alaskan NativePolynesian/MicronesianWhite/CaucasianOther (specify)	
How much do you identify with your <b>ethnic heritage</b> ? (Check one):	
Not at allA littleSomewhatModeratelyStrongly	
Religious/Spiritual Background:	
Do you consider yourself a religious person?YesNo or spiritual person?YesN  Explain:  Faith: Group/Denomination in which you were raised:  Current Congregation/Church:  How active are you? Inactive Slightly ModerateVery	0
How active are you?InactiveSlightly ModerateVery  Academic Background:	
-tademic background.	
Where did you attend high school?	
Did you attend college/professional school? When, where, degree earned?	
Any plans to further your education? If so, when and what?	





Phone: 210-802-4695

Please list any additional <b>information that you believe will be helpful</b> for your therapist to know.				
For Staff Use				
Therapist's comments:				
Therapist's signature/credentials:	Date:			
Supervisor's signature/credentials:	Date:			