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PERSONAL & HEALTH HISTORY (For couples each partner must complete their own form) (PLEASE PRINT)

Name ______________________________________ Age ________ Date ___________________

Address _______________________________ City _____________ State ______ Zip _______________

Relationship status: Married ____ Separated ____ Divorced ____ Widowed ____ Remarried ____
Single ____ Long Term Relationship ____ Cohabitating ____ Other _________________

If you are currently in a relationship, how satisfied are you with this relationship? _________________

How satisfied are you with your job/career? ____________________ Occupation___________________

Highest level of education ____

Do you have any children (biological, adopted, foster, step)____________________ Yes ____ No ____
If they do not live with you, where do they live and how often do you see them? __________________

____

If you were previously married or were in a committed long term relationship, please indicate:

Dates ____________________ Reason relationship ended ______________________________________

____

Did you have children: Yes ____ No ____

Have you ever been in therapy before? No ____ Yes ____ with whom and for how long? ___________

____ Was it a positive experience? _____________

If no, please indicate why ____

Have you ever been hospitalized? ______ If yes, please describe reason(s) and dates (please include physical health as well as for mental health reasons) ____

____

Do you have any chronic health conditions, medical conditions, or injuries? Yes ____ No ____
If yes, please describe ____

____

Continued . . .

PERSONAL & HEALTH HISTORY (page 2 of 3) Name________________________________

Please list any medications you are currently taking, including supplements ______________________

____

____

Physician's name _________________________ Physician for above meds if different _______________

What do you enjoy doing in your spare time? ____

____

Are there things that you used to do, or would like to do, but currently don't? ____________________

____

How would you describe your spiritual or religious beliefs? ______________________________________

____

Is there anything else you think would be important for me to know about you or your family at this time? ____

____

____

What prompted you to seek therapy, and what is it that you would like to achieve by seeking therapy?
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Continued . . .

PERSONAL & HEALTH HISTORY (page 3 of 3) Name________________________________

Please place a check mark next to any of the following that are currently problem areas for you (if any are in the past, but are no longer an issue, please put a (P) next to that item):

Assertiveness____
Parenting____
Bowel problems____
Nightmares____
Anger____
Poor appetite____
Memory____
Physical abuse____
Sexual problems____
Temper____
Drug use____
Decision making____
Motivation____
My past____
Sex drive____

Health problems____
Alcohol use____
Sexual orientation____
Loneliness____
Ulcers____
Lack energy____
Friends____
Children____
Divorce____
Depression____
Headaches____
Unhappiness____
Self-control____
Shame____
Childhood trauma____

Career____
Legal issues____
Relationship____
Concentration____
My thoughts____
Sleep____
Dating____
Parents____
Relaxation____
Sexual abuse____
Tiredness____
Fears____
Internet use____
Guilt____
Other____________

Stress____
Self-esteem___
Religion____
Confusion____
Education____
Anxiety____
Suicidal thoughts____
Insomnia____
Ambition____
Shyness____
Finances____
Job____
Sadness____
Crying____
____