## PERSONAL HISTORY QUESTIONNAIRE

Information provided is part of your confidential treatment record.

**PATIENT'S NAME: ________________________________**

**PARENT'S NAME (if minor) ______________________________**

**DATE OF BIRTH ____/___/_____ AGE: _____**

**HOME ADDRESS: Street _____________________________________________________**

**City or Town: ______________________________ PHONE NUMBER: ___________________**

Please give your reason(s) for seeking assistance today:
________________________________________________________________________________
________________________________________________________________________________
_______________________________________________________________________________

**REFERRED BY: _________________________________________________________**

Have you ever received mental health treatment in the past? **YES NO**
If yes, then specify dates, reasons, length of treatment, and whether you were ever hospitalized.______________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**FAMILY HISTORY**

**A. Marital Status: Single Married Partnered Widowed Divorced Separated**

**B. Present and prior marriages:**

**Year Married Length of Marriage Reason Marriage ended**

**1.**

**2.**

**3.**

**C. Are you having marriage difficulties? YES NO**

**D. Children: (ages and gender)**

**E. Parents' ages and health: Mother: Father:**
**(If deceased, please give dates)**

**F. Have your parents ever been separated? Divorced?**
**If yes, how old were you? With whom did you live?**
**If that parent remarried, how old were you then?**

**G. Siblings (Ages and genders):**

**H. Have any of your family members experienced emotional problems?**

**I. What was the highest grade you completed in school?**

**J. Recent job history: Job/how long employed?**

**1.**

**2.**

**3.**

**K. Have you ever had any involvement with the police or juvenile authorities?**

**L. Did your parents abuse drugs and/or alcohol? YES NO**

**HEALTH HISTORY**

**A. Nicotine Use: Current: YES NO Past: YES NO:**

**Type: ___________________________**

**B. Current alcohol and/or substance use:**

**Alcohol: (Specify # of drinks) Daily Weekly Less Frequently No use**

**Drugs: Almost Daily Weekly Less Frequently No use**

**C. Have you had any recent family stress? YES NO**
**If yes, explain:**

**D.** Are you experiencing suicidal thoughts? YES NO
Have you ever attempted to injure yourself? YES NO If yes, explain:

**E.** Have you ever experienced physical/sexual/emotional abuse or neglect? YES NO

**F.** List medical Illnesses/Medications taken.

**G.** Do you have any allergies?

**H.** Please indicate if you CURRENTLY are experiencing the following:

1. YES NO Any history of head injury?
2. YES NO Frequent headaches?
3. YES NO Acute or chronic pain and/or muscle tension?
4. YES NO Feelings of anxiety?
5. YES NO Unpleasant dreams?
6. YES NO Recurring or intrusive thoughts?
7. YES NO Thoughts of death or dying?
8. YES NO Sleep difficulties?
9. YES NO Recent weight gain or loss? Change in appetite? YES NO
10. YES NO Change of energy level?
11. YES NO Absence of joy or pleasure?
12. YES NO Engaged in fighting or property damage?
13. YES NO Terminated a pregnancy or delivered a child within the last six months?
14. YES NO Unable to concentrate and/or focus on daily routines?
15. YES NO Experienced unexplained forces/voices/images?
16. YES NO General feelings of depression/sadness/unhappiness?
17. YES NO Increased anger/irritation/frustration?
18. YES NO Increased need to be alone or to be left alone?
19. YES NO Frequent crying spells?
20. YES NO History of high blood pressure?
21. YES NO Panic attacks?
22. YES NO Financial distress?

**Thank you for completing the above information.**