

ADULT PERSONAL HISTORY FORM

(Rev. 8-12-13)

The purpose of this questionnaire is to obtain a comprehensive view of your background to save both you and your counselor time. Please be complete and accurate. This material is personal and will be kept confidential to the extent allowed by law. No one else, not even your closest relative or family doctor, is permitted to see this record without your written permission. *Please print or write clearly.*

Name: _____ Date of Birth: _____

Gender: _____ Race: _____ Living situation (town/farm, house/apartment, etc.): _____

How did you choose Oasis Counseling? _____ Employer/School: _____

Please list who lives in your home:

Person & relationship	Age	Person & relationship	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESENTING PROBLEM

Please explain why you decided to come in for counseling at this time: _____

Describe how these issues have affected your ability to function (at home, at school, or at work): _____

Circle any of the following that apply to you, and **rate** the intensity of the symptoms on a scale of 1-5.
(1 being very mild and 5 being intense)

Feel worried _____ Feel depressed _____ Overly watchful _____ Aggressive Behavior _____

Feel keyed up/restless _____ Feel disinterested _____ Easily startled _____ Can't control anger _____

Feel panicky _____ Trouble sleeping _____ Unusually talkative _____ Impulsive reactions _____

Anxious _____ Fatigue _____ Distractible _____ Hear strange voices _____

Irritable _____ Feel worthless _____ Can't make friends _____ Strange sensations _____

Easily fatigued _____ Thoughts of suicide _____ Can't keep a job _____ Low self-esteem _____

Obsessive thoughts _____ Suicide attempts _____ See strange things _____ Nightmares _____

Loss of control _____ Feel hopeless _____ Procrastinate _____ Feel detached _____

Irresistible urges _____ Periods of crying _____ Guilt _____ Odd behavior _____

Describe the following:

	Too much	About right	Not enough	Explain if this has changed in the recent past.
Appetite	_____	_____	_____	_____
Concentration	_____	_____	_____	_____
Sleep	_____	_____	_____	_____

Other symptoms or stressors (example: physical/medical, social, family, occupational, financial): _____

What would you like to achieve through counseling? _____

How will you know when you are ready to be done with counseling? What will have changed? _____

SOCIAL HISTORY

Please **circle** the words you would use to describe yourself when you were growing up:

Wanted Unwanted Happy Unhappy Special Insignificant Different Lonely

Active Daredevil Fearful Sad Athletic Even-tempered Shy Awkward

Fat Thin Outgoing Withdrawn Funny Popular Used People-pleaser

Describe your social life as a child and as a teen, in terms of your friendships and activities: _____

Describe any previous significant relationships and explain why they ended (dating, engaged, or married): _____

If you have experienced any of the following, please **circle** and **explain**: abortion affairs impotence
frequent change of sexual partners venereal disease homosexual experiences pornography

Please provide a brief job history, including positions held: _____

Describe any hobbies, sports, volunteer work, or interests you enjoy: _____

SPIRITUAL/CULTURAL

How would you explain the culture of your family? (Please include ethnicity, economic values, spirituality, or anything you consider to be significant. Explain what you felt was helpful and unhelpful.)

Do you believe in God? If yes, please explain your belief, including how important this belief is to you in your daily life and how you came to have this belief: _____

Which of the following statements apply to you?

- I have concerns about having religion forced upon me.
- I am uncomfortable discussing spiritual issues in my counseling sessions.
- I don't believe in God.
- I am interested in knowing God, but He seems far off to me.
- I am interested in finding a church home.
- God is an important part of my life.
- I go to church and read the Bible regularly.
- I have a personal relationship with Jesus Christ.
- I see God as an important part of the healing process & am open to using spiritual resources in therapy.

Please identify the denomination/church background which best describes you currently. If this is different from that which you experienced as a child, please indicate that as well. _____

How frequently do you access spiritual supports, i.e. church, Bible study, or Christian clubs? _____

FAMILY HISTORY

Did your biological parents raise you? Yes ____ No ____ If not, who raised you and why? _____

If relevant, how old were you when your parents separated or divorced? Why did they? _____
(or: N/A)

Describe your relationship with your mother or stepmother (or both): _____

Describe your relationship with your father or stepfather (or both): _____

If your parents abused drugs or alcohol or had other major problems, please describe: _____

How many times did you move during your growing-up years? _____ Explain how these moves affected you: _____

How many siblings do you have? _____ What number are you in the birth order? _____ What was your relationship like with your siblings? _____

If you have ever lived in a foster home, group home, or any institution-type home, please explain: _____

Describe any significant events during your childhood: _____

MARITAL AND/OR INTIMATE RELATIONSHIPS

Are you currently involved in a significant relationship? Yes No

Circle one: Single Married Separated Divorced Widowed Live-in relationship

Name of spouse/partner/significant other: _____. How long have you two been together? _____

How would you describe your relationship with your spouse/significant other: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> connected | <input type="checkbox"/> why I am here for counseling |
| <input type="checkbox"/> has good communication | <input type="checkbox"/> abusive |
| <input type="checkbox"/> based on shared values | <input type="checkbox"/> without boundaries |
| <input type="checkbox"/> rocky | <input type="checkbox"/> healthy and fulfilling |
| <input type="checkbox"/> filled with conflict | <input type="checkbox"/> up and down |
| <input type="checkbox"/> spiritual | <input type="checkbox"/> scary |
| <input type="checkbox"/> in need of work | <input type="checkbox"/> faithful |
| <input type="checkbox"/> a source of trouble for me | <input type="checkbox"/> unfaithful |
| <input type="checkbox"/> satisfying most of the time | <input type="checkbox"/> respectful |
| <input type="checkbox"/> almost never satisfying | <input type="checkbox"/> having lots of parenting problems |
| <input type="checkbox"/> a source of joy for me | <input type="checkbox"/> lacking in intimacy |
| <input type="checkbox"/> something I wish I could change | <input type="checkbox"/> having lots of problems with extended family |

Others: _____

If married, describe what your courtship or dating relationship was like. (Choose all that apply.)

- | | | | | |
|--|---|--------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> too long | <input type="checkbox"/> too short | <input type="checkbox"/> lots of fun | <input type="checkbox"/> rocky | <input type="checkbox"/> too rushed |
| <input type="checkbox"/> we shared many common interests | <input type="checkbox"/> what courtship? | | | |
| <input type="checkbox"/> we didn't prepare for marriage enough | <input type="checkbox"/> a time to prepare for marriage | | | |

Of the following characteristics/attributes, what attracted you to your partner? (Choose all that apply.)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> looks | <input type="checkbox"/> personality | <input type="checkbox"/> shared values | <input type="checkbox"/> shared faith in God |
| <input type="checkbox"/> common interests | <input type="checkbox"/> sense of fun and adventure | <input type="checkbox"/> intelligence | <input type="checkbox"/> kind and caring |
| <input type="checkbox"/> similar views about child raising | <input type="checkbox"/> similar family background | | |

If you are currently involved in any *other* significant/intimate relationships, please explain: _____

How has your relationship with your spouse/partner changed over time? _____

Describe how supportive your spouse/partner is of you being here for therapy: _____

If you need help resolving conflict and/or hard feelings between you and another person, please explain: _____

MENTAL HEALTH HISTORY

If you have ever been hospitalized for psychiatric reasons, please describe when (including dates), where, and why: _____

If you have ever been in therapy before, please describe why, when (including dates), with whom, and for how long: _____

How effective was your previous treatment? _____

ACADEMIC AND INTELLECTUAL HISTORY

Level of education achieved (Check the highest one.)

- Elementary School
- Middle School
- High School Diploma
- Associate Diploma – area of study: _____
- Bachelor’s Degree – area of study: _____
- Master’s Degree – area of study: _____
- Doctorate Degree – area of study: _____
- Other qualification – area of study: _____

Describe any behavior problems you had in school: _____

If you were ever expelled or suspended from school, explain why: _____

Describe any disabilities or struggles you had in school: _____

What were your grades like? _____

MEDICAL HISTORY

Approximate date of last physical exam: _____

Name and address of primary care physician: _____ (if none, put: N/A)

Do you give permission to Oasis Counseling International to contact your primary care physician to coordinate your treatment? _____

If yes, you will be asked to sign a Release of Information form.

If no, please sign here, indicating that you DO NOT want Oasis to contact the physician: _____

List any medically-related hospitalizations and the reason for hospitalizations: _____

List any childhood illnesses or injuries you experienced: _____

List any current medical problems or illnesses you are experiencing: _____

Describe how any of the above physical challenges have impacted your life: _____

MEDICATIONS AND DOSES

List any medication (including over-the-counter) you are currently taking or have taken in the last 6 months.

Medication	Dosage (m.g., times/day)	Date Started on Medication	Date Ended

List any allergies or adverse reactions you have had to medications: _____

LEGAL HISTORY

If you have ever been arrested, detained, or convicted, please describe, list the year(s), and tell the consequence:

Description	Year(s)	Consequence

OFFENDER HISTORY

If you have ever been the perpetrator of any kind of abuse or violence, please describe: _____

VICTIM ISSUES

Please **circle** any of the following you have experienced: Attempted suicide Suicidal preoccupation
Deliberate self-injury Other high-risk behaviors Sexual abuse Physical abuse Other form of abuse
Neglect Observing violence/abuse

Please explain anything you circled: _____

SUBSTANCE USE/ABUSE HISTORY

Has anyone in your family used or abused drugs or alcohol? _____ If yes, please explain: _____

If you have used any of the following drugs, please fill in the information requested in this chart:

	Caffeine	Tobacco	Alcohol	Marijuana	Metham- phetamine	Cocaine	Abuse of Pills	Other (Specify)
Typical Amount/ Frequency								
How Taken <i>(oral, nasal, smoke, IV, other [specify])</i>								
Age/Date of First Use								
Age/Date of Last Use								

PERSONAL STRENGTHS AND WEAKNESSES

Please describe any personal strengths, talents, skills, abilities, or accomplishments: _____

Please describe any personal weaknesses and needs you have: _____

Describe any preferences for therapy (language, learning style, approach): _____

COMMUNITY ACCESS AND SUPPORTS

Please list any family members, friends, or others whom you can ask for help or talk to when you need support.

COMMUNITY ACCESS / SOCIAL SUPPORTS

--Please put an "X" next to any of the following community supports with which you are **currently** involved.

--On the space provided, please indicate the **name** of the individual with whom you are working, if applicable.

--If you **would like to** be involved with a particular service/support that is listed here, please indicate that on the line provided. (This helps with transition planning and helps your therapist coordinate treatment with other professionals to provide consistent care. Your therapist will **not** contact any of these individuals without your written permission.)

- Legal services (attorney) _____
- Norfolk Rescue Mission (crisis housing) _____
- Correction services (probation or parole officer) _____
- Local church (pastor/priest) _____
- HHS case manager _____
- Liberty Centre (living &/or day services for adult mental health problems) _____
- Vocational Rehabilitation (employment assistance) _____
- Employment Works (job skill shadowing and support) _____
- Financial services (budget and debt counseling) _____
- Bright Horizons (domestic violence shelter and support) _____
- Alcoholics Anonymous or Narcotics Anonymous _____
- Al-Anon (support for family/friends of alcoholics) _____
- Community support (support/transport for mental health or substance abuse treatment) _____
- Family support (supervised visitation and education) _____
- Professional Partners (in-home planning for child/adolescent behavior problems) _____
- Parent-to-Parent Network (mentoring and peer support for parents) _____
- HUD or other housing assistance _____
- Developmental disability services (Envisions, etc.) _____
- Crisis hotline _____
- Medication management (psychiatrist or APRN) _____
- Psychological testing _____
- I.O.P. program (adolescent or adult intensive therapy for substance abuse) _____
- Community Health Care Clinic (low-income medical care) _____
- Recreation services (The Y, or other fitness facilities) _____
- Support group _____
- Physical/occupational/speech therapy _____
- Residential treatment (group home, halfway house) _____
- Rehabilitation treatment center _____
- Dietary services (nutritionist) _____
- Educational services (tutoring, after-school program) _____
- Mentoring program (Befriend, Teammates, Big Brother Big Sister) _____
- Any other services _____

Are you interested in learning about ADVANCE DIRECTIVES? These are arrangements, usually legal in nature, which one can make to provide for one's well-being should one become incapacitated or in the event of one's death. Oasis has information about some of these options. **Please indicate here if you are interested in learning about these options.** Yes ____ No ____ *If you choose "No," please sign and date here:*

Signature

Date

With my signature and date, I agree that the information in this history form is true to the best of my knowledge: _____

Thanks for your time and effort!