ADULT PERSONAL HISTORY FORM

Please complete and return. If you would like to provide additional information, please use the back of the form. Please submit any educational, neurological, or psychological records that you feel would benefit the therapist in learning about your you or your child.

General Information

Client Name:	Today's Date:	Sex:
Name of person completing form:	Client DOB:	Preferred contact phone #:
Relationship to client:	Social security #:	Alternative phone #:
Address:	Email address:	Emergency contact name/#:

Seeking the following Services:

- ☐ Relationship Development Intervention (RDI)
- ☐ Individual Therapy
- ☐ Behavioral Therapy
- ☐ Parent Training
- ☐ Couples Therapy
- ☐ Educational Consultation
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Pre-marital Therapy
- ☐ Other: please specify _____

Primary reason(s) for seeking services:

- ☐ Relational Issue
- ☐ Autism Spectrum
- ☐ Anger Management
- ☐ Work Issue
- ☐ Social Issues
- ☐ Parenting Issues
- ☐ Family Problems
- ☐ Development Delays
- ☐ Anxiety
- ☐ Coping
- ☐ Fear/phobias
- ☐ Compulsive Behaviors
- ☐ Depression
- ☐ Sexual Concerns
- ☐ Alcohol/Drugs
- ☐ Eating Disorder
- ☐ Sleeping problems
- ☐ Hyperactivity

Other mental health concerns (specify):

_____

_____

Please select:

___American Indian ___Asian ___Black ___ Hispanic ___Pacific Islander ___White

___Two or more races ___Other

Language(s) spoken at home: _____

Religion (if applicable): _____

Please answer the following questions to the best of your ability:

1. Goals: What are your goals for coming here? Please be as specific as possible.

_____

_____

2. Medical History: Please share anything notable about you or your child's medical status, including neurological problems and allergies.

- ☐ Abortion
- ☐ Asthma
- ☐ Blackouts
- ☐ Bronchitis
- ☐ Hives
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Congenital problems
- ☐ Croup
- ☐ Diabetes
- ☐ Sexually transmitted disease
- ☐ Dizziness
- ☐ Ear aches
- ☐ Ear infections
- ☐ Eczema
- ☐ Encephalitis
- ☐ Fevers
- ☐ Hay fever
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Hearing
- ☐ Rheumatic Fever
- ☐ Influenza
- ☐ Lead poisoning
- ☐ Measles
- ☐ Meningitis
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Muscular Dystrop
- ☐ Nose bleeds
- ☐ Other skin rashes
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Pregnancy
- ☐ Speech
- ☐ Sensory/Motor

- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Severe Colds
- ☐ Meningitis
- ☐ Headaches
- ☐ Thyroid disorders
- ☐ Vision problems
- ☐ Wearing glasses
- ☐ Whooping cough
- ☐ Other _____

List any current health concerns: _____

_____

_____

List any recent health or physical changes: _____

_____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over the counter medications	Dose	Dates	Purpose	Side effects

3. Counseling/Prior Treatment History: Please share with me about any prior counseling that you have received. What worked? What did not work?