Peninsula Pastoral Counseling Center

PERSONAL HISTORY FORM

Introduction:

Thanks for your cooperation with this questionnaire. It's a way for your counselor to get to know you better, so that your counseling here may be more useful for you. The time that you take now with these questions frees up the time that you have with your counselor, so that you can discuss what's the most important.

There are a lot of questions. They are intended to determine the particular help that our clients need. Although some of these questions may not apply to you at all, we trust that many of them do. We appreciate your patience with any questions that aren't very relevant for you. If you need more space, we've set aside page 7 for that purpose. If that's not enough, ask the receptionist to provide more paper.

Your answers to this questionnaire are just as confidential as your counseling is. The "Consent to Treatment" form and the "HIPAA" privacy information describe the extent and the limits of confidentiality.

If you want to discuss your answers with your therapist, please say so. *Of course, you may decline to answer any questions on this form and discuss the matter in person with your therapist instead.*

If you have any questions about this form or anything else regarding your counseling here, please ask your counselor.

Basic Facts

Name _____ Date _____

Sex ___ Date of Birth _____Age:_____ Social Security Number _____

StreetAddress _____City_____ZIP_____

Phone (Home) _____ Emergency Contact (person) _____
(Work) _____ (phone) _____
(Cell phone) _____

Life Status

Single _____
Married ___ date _____
Widowed ___ date _____
Divorced ___ date _____
Separated ___ date _____
Living Together ___ date _____

African American _____
Asian-American _____
Caucasian-American ___
Hispanic-American___
Native American ___
Other _____

Dates of Previous Marriages:
married sep. div. wid.
1. _____
2._____
3._____
4._____

Religious affiliation, if any:_____

Your Nuclear Family

Persons currently living with you in your home (name, birth year, and relationship): _____

_____

_____

Immediate family members living elsewhere (name, birth year, and relationship): _____

_____

Religious background(s) of your household (if none, state none)._____

_____

Parental Family

Father
Name _____ Birth year _____

Occupation _____

If deceased, date and cause of death:

_____

Mother
Name _____Birth year _____

Occupation _____

If deceased, date and cause of death:

_____

Stepparents (name, birth year, relationship, occupation) _____

_____

Siblings/Stepsiblings (name, birth year, relationship) _____

_____

Religious background(s) of parental family (if none, state none)._____

_____

Educational & Vocational History

Education (highest level completed and date**)** _____

Additional education or vocational training since high school (dates, schools, programs, degrees, certificates, etc.) _

_____

Current Employer: _____
Full time ____ Part time ____ Temporary ____ Unemployed ____ Disabled ____ Retired ____ Student ____
Homemaker ____ Other _____

Previous Occupations: _____

Military Service (dates and branch) _____

Spiritual/Religious

Please describe your personal religious background and present faith perspective, if any:_____

_____

Are there any spiritual/religious issues involved in the problems that bring you here?_____

_____

Is there a way that you prefer that faith issues be dealt with in counseling or not?_____

Current church you are attending, if any_____

Medical History

Medical history may be important for understanding and treating emotional issues and relationship problems. Please describe any significant health issues, injuries, etc. for yourself and your family. If needed, use the space on page 7 or ask the receptionist for extra pages if needed.

(Please list medications/herbs that you currently are taking on the “Medication” form)

Do you currently have any physical problems? No ____ Yes (specify) _____

_____

_____

Do you have a primary care practitioner? No ____ Yes (name, address, phone) _____

_____

For each of the following, please indicate your present and past use.

Tobacco

Ever used? Yes No (circle one) If never used, skip to next question.

Type_____

Dates of use_____

Amount/frequency of use_____

Impact on your life._____

Alcohol

Ever used? Yes No (circle one) If never used, skip to next question.

Dates of use_____

Amount/frequency of use_____

Impact on your life._____

Prescription medications

Ever used? Yes No (circle one)

If yes, please list on the last page, “Medication”.

If never used, skip to next question.

Impact on your life._____

Used beyond what was prescribed? Yes No (circle one)

For each of the following, please indicate your present and past use. (continued)

Over the counter medications/herbal products/etc.

Ever used? Yes No (circle one) If never used, skip to next question.

Type _____

Dates of use_____

Amount/frequency of use_____

Impact on your life._____

Used beyond what was recommended? Yes No (circle one)

Illegal drugs

Ever used? Yes No (circle one) If never used, skip to next question.

Type _____

Dates of use_____

Amount/frequency of use_____

Impact on your life._____

Therapeutic Background

Are you currently in treatment with a psychiatrist, psychologist, or other mental health professional? No ___ Yes__

If yes, please list the name of the therapist _____

Have you had previous therapy? No ____ Yes (name of therapist(s), date(s), and outcomes) _____

_____

_____

Have you been hospitalized for psychiatric treatment? No ____ Yes (specify hospital(s), date(s), and outcomes)

_____

Do you have any suicidal or homicidal thoughts at the present time? No ____ Yes ____
If yes, do you have any suicidal or homicidal plans? No ____ Yes ____
If yes, do you intend to carry out your plans? No ____ Yes ____

Currently, is somebody harming you physically, emotionally, sexually, or otherwise? Yes No (circle one)

Do you currently fear that somebody will harm you in these ways? Yes No (circle one)

Have you been harmed in these ways in the past? Yes No (circle one)

Present Concerns

Briefly note the concerns that bring you to therapy and the results that you hope to achieve _____

_____

_____

_____

_____

_____

How have you tended to deal with similar problems in the past?_____

_____

_____

What personal strengths do you have in dealing with the problems that bring you here?

_____

_____

What contributions from other people in your life (family, work, social, religious, etc.) make it easier for you to cope with these problems?

_____

_____

What problems with other people in your life (family, work, social, religious, etc.) make it harder for you to cope with these problems?

_____

Who will suffer most because of these problems?

_____

Who will suffer least because of these problems?

_____

How long do you think it will take you to resolve these problems?

_____

Referral:

How did you hear about us? _____

If you were sent by a professional, may we thank that person? Please initial _____yes _____no

If yes, please give name, address, or phone number _____

What Else Do You Want to Tell Us?

Signature _____ **Date** _____

“Overflow” from Previous Questions

If you didn’t have room to answer some questions, use this space. If you need more paper, ask the receptionist.

Medication

Many medications have an effect on thinking, feeling, and relationships, whether by design or as a side effect. Some herbal products have similar effect. So it may be useful for your pastoral counseling to know what medications you are taking, whether by prescription or over the counter. (If you need another page, please ask the receptionist.)

Client Name	Medication or herb; dosage	Dates used	Medical Doctor, phone number	Purpose, side effects, and other comments