First Step

Counseling &
Educational Services, LLC

ADULT PERSONAL HISTORY
(Ages 18 & Older)

Name _____ Age _____ Date _____

Person completing form _____ Relationship to Client _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone Number _____

Please take your time to complete this entire form as best you can. This information will help us understand you better. Thank you.

Please tell us if a specific event has caused you to seek help now.

_____

_____

What would you like us to help you with?

_____

_____

_____

Relationship	Full Name If deceased, please list year & cause	Age	Living with you (Circle answer)	Current or History of:
Father			☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
Mother			☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
Spouse			☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
Partner			☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
Children:	**1.**		☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
	2.		☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
	3.		☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
Siblings:	**1.**		☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
	2.		☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse
	3.		☐ Yes ☐ No	☐Mental Health Concerns ☐Substance Abuse

BEHAVIORS/SYMPTOMS: Please check all boxes that you have experienced during the past 12 months.

☐ Aggressive Behavior
☐ Alcohol Dependency
☐ Anger Issues
☐ Anxiety/Panic Attacks
☐ Avoiding People
☐ Change in Appetite
☐ Change in Grooming
☐ Chest Pains
☐ Crying Spells
☐ Cyber Addiction
☐ Decreased Activity
☐ Depression
☐ Disorientation
☐ Dizziness
☐ Drug Dependence
☐ Eating Disorder
☐ Elevated Mood
☐ Family-related Stress
☐ Fear of Dying
☐ Financial Worries
☐ Guilt/Shame
☐ Hearing Voices
☐ Hopelessness
☐ Impulsive Behavior
☐ Mood Swings
☐ Nightmares
☐ Physical Outbursts
☐ Racing Thoughts
☐ Relationship Issues
☐ Self-isolation
☐ Sexual Concerns
☐ Verbal Outbursts
☐ Withdrawal Symptoms
☐ Work-related Stress

Please provide details related to above checked boxes:

_____

_____

_____

<u>RISK ASSESSMENTS</u>: In order to help us understand how to keep you safe, please tell us about the following:

1. In the past month have you wished you were dead or wished that you would die in your sleep?* ☐ Yes ☐ No

2. Have you had thoughts of suicide or harming yourself in other ways?* ☐ Yes ☐ No

3. Have you thought about or made any preparation to end your life?* ☐ Yes ☐ No

In your lifetime, how many times have you done any of these things? _____

Therapist must complete Columbia-Suicide Severity Rating Scale (Intake Assessment) if "YES" to questions 1, 2, or 3.

4. In the past month, have you wanted to harm or kill another person? ☐ Yes ☐ No

If YES to 4, answer questions 5, 6, 7, 8, and 9. If NO to 4, go directly to 9.

5. Have you thought about how you might do this? ☐ Yes ☐ No

6. Have you had any intention of acting on these thoughts? ☐ Yes ☐ No

7. Have you started to work out or worked out the details of how to harm or kill another? ☐ Yes ☐ No

Do you intend to carry out this plan? ☐ Yes ☐ No

8. Have you done anything, started anything or prepared to do anything to harm/kill someone else? ☐ Yes ☐ No

In your entire lifetime, how many times have you done any of these things? _____

9. Have you ever experienced (check all that apply):

☐ Verbal Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Other Trauma

Please provide details about any checked boxes above: _____

_____

PHQ-9
PATIENT HEALTH QUESTIONNAIRE

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
For each question in the chart below, place an X in one box that best describes your answer.

Questions	0	1	2	3
1. Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
2. Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling or staying asleep or sleeping too much	Not at all	Several days	More than half the days	Nearly every day
4. Feeling tired or having little energy	Not at all	Several days	More than half the days	Nearly every day
5. Poor appetite or overeating	Not at all	Several days	More than half the days	Nearly every day
6. Feeling bad about yourself – or that you are a failure or have let yourself or family down	Not at all	Several days	More than half the days	Nearly every day
7. Trouble concentrating on things, such	Not at all	Several days	More than	Nearly every day

as reading the newspaper or watching television			half the days	
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	Not at all	Several days	More than half the days	Nearly every day
9. Thoughts that you would be better off dead or of hurting yourself in some way	Not at all	Several days	More than half the days	Nearly every day
Total of Each Column:				
Total Score:				

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

AUDIT
Alcohol Use Disorders Identification Test

Alcohol use can affect your health and can interfere with certain medications and treatments. It is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.
For each question in the chart below, place an X in one box that best describes your answer.

Questions	0	1	2	3	4	SCORE
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	Daily or almost daily	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

going after a heavy drinking session?						
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been inquired because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	
Last Date of Alcohol Use:						

First Step

Counseling &
Educational Services, LLC

The use of various substances, legal and not legal, can affect your health and can interfere with certain medications and treatments. It is important that we ask some questions about your use of all substances. Your answers will remain confidential, so please be honest.

For each question in the chart below, please provide information that best describes your use.

Substance	Age of 1st Use	Age you were using regularly	Average number of days used each week	Usual amount used in a day	Number of days used in the last 30 days	Amount used in the last 48 hours	Date/Amount last used
Coffee, Soda, Caffeine Pills							
Cigarettes							
Marijuana							
Crack/Cocaine							
Heroin/IV Heroin							
Methadone							
Pain Pills Type:							
Muscle relaxers: Soma, Flexeril, Other:							
Tranquilizer: Valium,							

Xanax, Klonopin, Other:							
Inhalents, Glue, Poppers, Aerosols							
PCP, LSD, Mescaline							
Meth-amphetamine, Speed, Ritalin, Adderall							
Phenobarbital, Sleeping Pills							
Steroids							
Over-the-Counter Drug:							
Other:							
What are your drugs of preference?							

Physical Health: Please check all boxes that apply to you now or in the past.

☐ Asthma
☐ Chronic Fatigue
☐ Liver Disease
☐ Migraines
☐ STD's
☐ Ulcers
☐ Cholesterol
☐ Heart Disease
☐ Pregnancy
☐ Irritable Bowel
☐ Vision Problems
☐ Speech Problems
☐ HIV/AIDS
☐ Menopause
☐ Cancer
_____
☐ Hepatitis
☐ Diabetes
☐ Seizures
☐ Chronic Pain
☐ Thyroid Issues
☐ Hearing Problems
☐ Head Injury
☐ Abnormal Blood Pressure
☐ Other:
_____

Primary Care Physician's Name: _____

Physician's Address: _____ Phone: _____

Date of your last physical: _____ Receiving ongoing care? ☐ Yes ☐ No

Please list all medications/dosages you are currently prescribed: _____

_____

Do you have an Advanced Directive? ☐ Yes ☐ No If yes, ☐ Mental Health ☐ Medical

Would you like information about Advanced Directives? ☐ Yes ☐ No

Previous Mental Health Treatment

Have you seen a counselor/therapist in the past? ☐ Yes ☐ No If yes, please answer the questions below:

Reason(s) you sought help: _____

Approximate dates: _____ Was it helpful? ☐ Yes ☐ No

Have you been hospitalized for mental health reasons? ☐ Yes ☐ No If yes, please answer the questions below:

Reason(s) you were hospitalized: _____

_____

Approximate dates: _____ Was it helpful? ☐ Yes ☐ No

Did you participate in recommended treatment after discharge from hospital? ☐ Yes ☐ No

Previous Substance Abuse Treatment

Have you participated in substance abuse treatment in the past? ☐ Yes ☐ No

If yes, please answer the questions below:

Substance(s) you were using: _____

Reason(s) you sought help: _____

_____

Approximate dates: _____ Was it helpful? ☐ Yes ☐ No

Have you ever overdosed on a substance(s)? ☐ Yes ☐ No How many times? _____ Dates: _____

Have you been in Residential Substance Abuse Treatment? ☐ Yes ☐ No

If yes, approximate dates: _____

What has helped you stay sober in the past? _____

Longest period you have been sober: _____

Ethnic/Cultural Background Please share any information about your ethnic or cultural preferences that may impact your treatment: _____

_____

Religious/Spiritual Background Please share any information about your religious or spiritual preferences that may impact your treatment: _____

_____

Sexual/Gender Background Please share any information about your sexual or gender identity that may impact your treatment: _____

_____

Childhood Who were you raised by? _____

Education Are you currently a student? ☐ Yes ☐ No Last grade completed? _____

Have you ever been diagnosed with a learning disability? ☐ Yes ☐ No If yes, age/diagnosis? _____

Employment Are you currently working? ☐ Yes ☐ No If yes, what is your job? _____

Have you ever been fired from a job(s)? ☐ Yes ☐ No If yes, why? _____

Are you at risk of losing your job now? ☐ Yes ☐ No If yes, why? _____

Financial Do you have an income? ☐ Yes ☐ No If yes, from where? _____

Do you feel your income is enough to support you/your family? ☐ Yes ☐ No

Military Service Did you serve in the Military? ☐ Yes ☐ No If yes, what branch? _____

Dates served & type of discharge? _____

Did you experience combat? ☐ Yes ☐ No If yes, dates? _____

Legal

Arrest History	Arrest Date	Amount of Time Served	Parole/Probation End Date
Charge: _____ ☐ Open Case ☐ Closed Case ☐ Convicted? ☐ Yes ☐ No		☐ Jail ☐ Prison	☐ Parole ☐ Probation
Charge: _____ ☐ Open Case ☐ Closed Case ☐ Convicted? ☐ Yes ☐ No		☐ Jail ☐ Prison	☐ Parole ☐ Probation
Charge: _____ ☐ Open Case ☐ Closed Case ☐ Convicted? ☐ Yes ☐ No		☐ Jail ☐ Prison	☐ Parole ☐ Probation

Therapist/Credentials: _____ Date: _____

Consultant/Psychiatrist Signature: _____ Date: _____