SIGIL
SOCIAL FOUNDATION

Personal History —Adult (18+)

Client's name: _____ Date: _____

Gender: _____ F _____ M Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____ (work): _____ ext: _____

Phone (cell): _____

If you need any more space for any of the questions, please use the back of the sheet.

Primary reason(s) for seeking services

___ Anger management ___ Anxiety ___ Coping ___ Depression

___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concers

___ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs

___ Other mental health concerns (specify): _____

Family Information

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No
Mother						
Father						
Spouse						
Children						

Significant others (e.g., brother, sisters, grandparents, steprelatives, half relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No

Marital Status (more than one answer may apply)

_____ Single

_____ Divorce in process
Length of time: _____

_____ Unmarried, living together
Length of time: _____

_____ Legally married
Length of time: _____

_____ Separated
Length of time: _____

_____ Divorced
Length of time: _____

_____ Widowed
Length of time: _____

_____ Annulment
Length of time: _____

Total number of marriages: _____

Assessment of current relationship (if applicable): _____ Good _____ Fair _____ Poor

Parental Information

_____ Parents legally married

_____ Parents have ever been separated

_____ Parents ever divorced

_____ Mother remarried: Number of times: _____

_____ Father remarried: Number of times: _____

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? _____Yes _____ No

If Yes, please describe: _____

Has there been history of child abuse? _____ Yes _____ No

If Yes, which type(s)? _____ Sexual _____ Physical _____ Verbal

If Yes, the abuse was as a: _____ Victim _____ Perpetrator

Other childhood issues: _____ Neglect _____ Inadequate nutrition _____ Other (please specify): _____

Comments re: childhood development: _____

_____

Social Relationships

Check how you generally get along with other people: (check all that apply)

_____ Affectionate _____ Aggressive _____ Avoidant _____ Fight/argue often _____ Follower

_____ Friendly _____ Leader _____ Outgoing _____ Shy/withdrawn _____ Submissive

_____ Other (specify): _____

Sexual orientation: _____ Comments: _____

Sexual dysfunctions? _____ Yes _____ No

If Yes, describe: _____

Any current or history of being as sexual perpetrator? _____ Yes _____ No

If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? _____ Yes _____ No

If Yes, describe: _____

Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? ____ Not ____ Little ____ Moderate ____ Much

Are you affiliated with a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes ____ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

_____

Are you presently on probation or parole? ____ Yes ____ No

If Yes, please describe: _____

Past History

Traffic violations: ____ Yes ____ No DWI, DUI, etc.: ____ Yes ____ No

Criminal involvement: ____ Yes ____ No Civil involvement: ____ Yes ____ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

_____

Education

Fill in all that apply: Years of education: ____ Currently enrolled in school? ____ Yes ____ No

____ High school grad/GED

____ Vocational: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

____ College: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

____ Graduate: Number of years: ____ Graduated: ____ Yes ____ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

_____

Currently: _____ FT _____ PT _____ Temp _____ Laid-off _____ Disabled _____ Retired
_____ Social Security _____ Student _____ Other (describe): _____

Military

Military experience? _____ Yes _____ No Combat experience? _____ Yes _____ No

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

_____ AIDS
_____ Alcoholism
_____ Abdominal pain
_____ Abortion
_____ Allergies
_____ Anemia
_____ Appendicitis
_____ Arthritis
_____ Asthma
_____ Bronchitis
_____ Bed-wetting
_____ Cancer
_____ Chest pain
_____ Chronic pain
_____ Colds/Coughs
_____ Constipation
_____ Chicken pox
_____ Dental problems
_____ Diabetes
_____ Diarrhea
_____ Dizziness
_____ Drug abuse
_____ Epilepsy
_____ Ear infections
_____ Eating problems
_____ Fainting
_____ Fatigue
_____ Frequent urination
_____ Headaches
_____ Hearing problems
_____ Hepatitis
_____ High blood pressure
_____ Kidney problems
_____ Measles
_____ Mononucleosis
_____ Mumps
_____ Menstrual pain
_____ Miscarriages
_____ Neurological disorders
_____ Nausea
_____ Nose bleeds
_____ Pneumonia
_____ Rheumatic fever
_____ Sexually transmitted diseases
_____ Sleeping disorders
_____ Sore throat
_____ Scarlet fever
_____ Sinusitis
_____ Smallpox
_____ Stroke
_____ Sexual problems
_____ Tonsillitis
_____ Tuberculosis
_____ Toothache
_____ Thyroid problems
_____ Vision problems
_____ Vomiting
_____ Whooping cough
_____ Other (describe): _____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	____ /week	_____	____ No	____ Low	____ Med	____ High
Lunch	____ /week	_____	____ No	____ Low	____ Med	____ High
Dinner	____ /week	_____	____ No	____ Low	____ Med	____ High
Snacks	____ /week	_____	____ No	____ Low	____ Med	____ High

Comments: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ____ Yes ____ No

If Yes, describe: _____

_____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

_____

Family history of medical problems: _____

_____

Please check if there have been any recent changes in the following:

____ Sleep patterns ____ Eating patterns ____ Behavior ____ Energy level

____ Physical activity level ____ General disposition ____ Weight ____ Nervousness/tension

Describe changes in areas in which you checked above: _____

_____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol								
Barbiturates								
Valium/Librium								
Cocaine/Crack								
Heroin /Opiates								
Marijuana								
PCP/LSD/Mescaline								
Inhalants								
Caffeine								
Nicotine								
Over the counter								
Prescription drugs								
Other drugs								

Substance of preference

1. _____ 3. _____
2. _____ 4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

_____

Describe any changes in your use patterns: _____

_____

Describe how your use has affected your family or friends (include their perceptions of your use): ____

_____

Reason(s) for use:

____ Addicted ____ Build confidence ____ Escape ____ Self-medication

____ Socialization ____ Taste ____ Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/has someone in your family present/past have/had a problem with drugs or alcohol?

____ Yes ____ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ____ Yes ____ No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

_____

Have drugs or alcohol created a problem for your job? _____ Yes _____ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitaiizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitaiizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

_____ Aggression
_____ Alcohol dependence
_____ Anger
_____ Antisocial behavior
_____ Anxiety
_____ Avoiding people
_____ Chest pain
_____ Cyber addiction
_____ Depression
_____ Disorientation
_____ Distractibility
_____ Dizziness
_____ Drug dependence
_____ Eating disorder
_____ Elevated mood
_____ Fatigue
_____ Gambling
_____ Hallucinations
_____ Heart palpitations
_____ High blood pressure
_____ Hopelessness
_____ Impulsivity
_____ Irritability
_____ Judgment errors
_____ Loneliness
_____ Memory impairment
_____ Mood shifts
_____ Panic attacks
_____ Phobias/fears
_____ Recurring thoughts
_____ Sexual addiction
_____ Sexual difficulties
_____ Sick often
_____ Sleeping problems
_____ Speech problems
_____ Suicidal thoughts
_____ Thoughts disorganized
_____ Trembling
_____ Withdrawing
_____ Worrying
_____ Other (specify): _____
_____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

_____

_____

_____

_____

_____

_____

Any additional information that would assist us in understanding your concerns or problems: _____

_____

_____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

_____

_____

_____

Do you feel suicidal at this time? _____ Yes _____ No

If Yes, explain: _____

_____

_____

_____

For Staff Use

Therapist's signature/credentials: _____ Date: _____/_____/_____

Supervisor's comments: _____

_____

_____ Physical exam: _____ Required _____ Not required

Supervisor's signature/credentials: _____ Date: _____/_____/_____

(Certifies case assignment, level of care and need for exam)