Azimuth Counseling and Therapeutic Services

8 Essex Way, Suite 101
Essex, VT 05452

Personal History—Adult (18+)

UPDATED 7/28/16

Client's name: ____ Date: _____ / _____ / _____

Gender: ____ F ____ M Date of birth: _____ / _____ / _____ Age: ______

Location of birth:____

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

Address: ______________________ City: ____________________ State: ____ Zip: _______

Phone (home): ______________ (cell): _____________ (work): _____________ ext: ______

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
- ❑ Eating disorder
- ❑ Sleeping problems
- ❑ Anxiety
- ❑ Fear/phobias
- ❑ Alcohol/drugs
- ❑ Coping
- ❑ Mental confusion
- ❑ Addictive behaviors
- ❑ Depression
- ❑ Sexual concerns
- ❑ Other mental health concerns (*specify*): ____

Family Information

Relationship	Name	Age	Living	Living with you
Parent			❑ Yes ❑ No	❑ Yes ❑ No
Parent			❑ Yes ❑ No	❑ Yes ❑ No
Spouse			❑ Yes ❑ No	❑ Yes ❑ No
Children			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No

Significant others:
(e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living	Living with you
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No

Marital Status (more than one answer may apply)

____ Single
____ Divorce in process
____ 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
____ Parent remarried   Number of times: ________
____ Parents have never been separated
____ Parent remarried: Number of times: ________
____ Parents ever divorced

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 job	Missed work how often?

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

Military

Military experience? ____ Yes ____ No (If *No*, go to next section)

Combat experience? ____ Yes ____ No Where:____

Branch: ___________ Date drafted: _____ / _____ / _____ Date enlisted: _____ / _____ / _____

Discharge date: _____ / _____ / _____

Type of discharge: _____ / _____ / _____ 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 disease
- ❑ 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
Snack	/week		❑ No ❑ Low ❑ Med ❑ High
Comments			

Current prescribed medications

Current prescribed medications	Dose	Dates	Purpose	Side effects

Current over-the-counter (OTC) medications

Current OTC medications	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			
Upcoming surgery			

Family history of medical problems: ____

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

❑ Sleep patterns ❑ Energy level ❑ Weight

❑ Eating patterns ❑ Physical activity level ❑ Nervousness/tension

❑ Behavior ❑ General disposition

Describe changes in areas in which you checked above: ______________________________

____

Chemical Use History

Chemical	Method of use	Frequency of use	Age of first use	Age of last use	Used in last 48 hours	Used in last 30 days
Alcohol					❑ Y ❑ N	❑ Y ❑ N
Barbiturates					❑ Y ❑ N	❑ Y ❑ N
Valium/Librium					❑ Y ❑ N	❑ Y ❑ N
Cocaine/Crack					❑ Y ❑ N	❑ Y ❑ N
Heroin/Opiates					❑ Y ❑ N	❑ Y ❑ N
Marijuana					❑ Y ❑ N	❑ Y ❑ N
PCP/LSD/Mescaline					❑ Y ❑ N	❑ Y ❑ N
Inhalants					❑ Y ❑ N	❑ Y ❑ N
Caffeine					❑ Y ❑ N	❑ Y ❑ N
Nicotine					❑ Y ❑ N	❑ Y ❑ N
Over the counter					❑ Y ❑ N	❑ Y ❑ N
Prescription drugs					❑ Y ❑ N	❑ Y ❑ N
Other drugs					❑ Y ❑ N	❑ Y ❑ N

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 ____ Self-medication ____ Taste

____ Escape ____ Socialization

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*): ______________________

____

Does your body temperature change when you drink? ____ Yes ____ No

If Yes, 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	❑ Y ❑ N			
Suicidal thoughts/attempts	❑ Y ❑ N			
Drug/alcohol treatment	❑ Y ❑ N			
Hospitalizations	❑ Y ❑ N			
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	❑ Y ❑ N			

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

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

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? ______________________________________

____

____

Clinician Signature: ____

Job Title/Credentials: ____