

Personal History Form

Name _____ Todays Date _____
Date of Birth _____ Religion / Spirituality _____
Race / Ethnicity _____
Home Address _____ City _____ State _____ Zip code _____
Local Address (if WCU Student) _____ City _____ State _____ Zip code _____
Home Phone _____ Ok to leave message? Yes No
Mobile Phone _____ Ok to leave message? Yes No

Information for Clients

Your intake consists of a series of questionnaires and an interview lasting about 90 minutes. Rather than focus on a list of questions during your initial interview we prefer to focus on your current problem and how we can help you. Completing this form will help with that process.

Intake Questions

Current living situation Apartment/Rent Own Home
Do you live alone? Yes No

If no, please list the names and relationships of the people you live with.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Please tell us about any concerns you have regarding your current housing situation.

Current Employer _____ Length of Employment _____

Please tell us about any concerns you have regarding your current employment situation.

Primary Physician name and phone number:

Are you attending school? Yes No Full-time Part-time

Name of School _____

Status: Freshman Sophomore Junior Senior

Please tell us about any concerns you have regarding school.

Please tell us your gender.

Please tell us your sexual orientation.

Please tell us any concerns you have regarding your relationship status, gender, or sexual orientation.

Have you ever been told that you have a thyroid problem? Yes No Unsure

Do you have a history of: (check all that apply)

Asthma/COPD Stroke Chronic Pain Anemia Cancer
Difficult pregnancy, labor, or delivery Ulcers

Do you have any medication or food allergies? Yes No Unsure

If yes, please specify: _____

Do you have any current medical conditions? Yes No Unsure

If yes, please specify: _____

Do you have any history of concussions / loss of consciousness? Yes No Unsure

If yes, when? _____

Do you have any previous psychiatric diagnoses? Yes No Unsure

If yes, please specify: _____

Have you ever been hospitalized for any emotional or psychiatric reason? Yes No Unsure

If yes, how many times have you been hospitalized? _____

Date	Name of Hospital	Reason for Hospitalization	Was it helpful?

Have you ever received psychiatric or psychological treatment before (e.g. counseling)? Yes No Unsure

If yes, please complete:

Date	Name of Clinician	Reason for Treatment	Was it helpful?

Are you taking any medication for psychiatric reasons? Yes No Unsure

If yes, please complete:

Medication	Dose	Frequency	Name of Prescriber

Have you ever made a suicide attempt? Yes No Unsure

If yes, how many times? _____

Approximate Date	What did you do to hurt yourself?	Were you hospitalized?

Have you ever experienced emotional or verbal abuse as a child? Yes No Unsure

Have you ever experienced sexual abuse as a child? Yes No Unsure

Have you ever experienced non-sexual abuse as a child? Yes No Unsure

Have you ever experienced being raped (including acquaintance and marital rape)? Yes No Unsure

Have you ever experienced emotional or verbal abuse as an adult? Yes No Unsure

Have you ever experienced non-sexual physical abuse as an adult? Yes No Unsure

Have you ever been concerned about your sexual behavior in terms of unusual practices, addiction, high-risk, identity confusion, or other matters?
Yes No Unsure

Do you have any criminal history, including arrests and penalties, or are you currently involved in any legal actions?
Yes No Unsure

Has anyone in your family ever made a suicide attempt? Yes No Unsure
If so, how is this person related to you? _____

Has anyone in your family died from suicide? Yes No Unsure
If so, how is this person related to you? _____

Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse, or other addictions? Yes No Unsure
If so, how are these persons related to you, and what is a summary of their problems?

Do you have any concerns in any of the following areas? Check all that apply.

Appetite Sleep Concentration / Memory Energy Motivation

Physiological symptoms (heart racing, shortness of breath, hands trembling, nausea, etc.)

Ability to enjoy pleasurable activities Helpless / Hopeless / Worthless Hearing / Seeing things that others do not see

Paranoia Other

If other, please specify: _____

Did you complete this form: Independently -or- With the help of someone

If someone helped you, who was it? _____

****Continue onto back for scheduling preferences**

Scheduling Preferences

Services Requested (check all that apply): Individual Couples Group Family

Please provide your availability for appointments below:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____