Adult Personal History Form

Name ____

Date of Birth ____

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 ___________________ Job Title__________________ Length of Employment _______________________

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

____.

Primary Physician name and phone number: ____

Date of last Physical Exam__________________________________

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

Name of School ____

Status: Freshman Sophomore Junior Senior

Highest grade level completed: ______________________________________

Please tell us about any concerns you have regarding school.

____

What is your gender? _______________________ What is your sexual orientation? _______________________________

With what, if any, Religion or Spiritual Practice do you identify?____

What Race (s) do you identify as? _____________________ Please provide Ethnicity ______________________________

Do you have concerns regarding your gender, religion, sexual orientation, race or ethnicity?________ If yes, please describe:____

What is your Relationship status? ____

Do you have concerns regarding your relationship status?____

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

If yes, please specify: ____

Do you have any current or past 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, and name of person who diagnosed you: ____

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	Length of Stay

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	For How long?

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?

Place a checkmark next to each item that you <u>experienced prior to your 18th birthday</u>:	✓
Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
Did you lose a parent through divorce, abandonment, death, or other reason?	
Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
Did you live with anyone who went to jail or prison?	
Did a parent or adult in your home ever swear at you, insult you, or put you down?	
Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
Did you feel that no one in your family loved you or thought you were special?	
Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
Do you believe that these experiences have affected your health? (circle one) ***Not much*** ***Some*** ***A lot***	

Do you have access to firearms? Yes No Unsure

Have you ever been 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

Do you have any criminal history, including arrests and penalties, or are you currently involved in any legal actions?

Explain:____

Has anyone in your family or close friend ever made a suicide attempt? Yes No Unsure

If so, how is this person related to you? ______________________________

Has anyone in your family or close friend 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?

____

____

____

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

If someone helped you, who was it? ____

Scheduling Preferences

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

Please provide your availability for appointments below:

Monday: (noon to 7pm)____

Tuesday: (noon to 7pm)____

Wednesday: (8am to noon)____

Thursday: (8am to 4pm)____