

## 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.

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

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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: \_\_\_\_\_