

Personal History Questionnaire / Intake Form

IDENTIFYING INFORMATION

First Name : _____

Identifier (see email): _____

Age: _____

Marital/Relationship Status: _____

Indicate your ethnic heritage and the role ethnicity currently plays in your life:

Indicate your religion and the role religion currently plays in your life:

Were you self-referred or how did you end up deciding to get help at this time?

PRESENTING PROBLEM:

Describe the concerns or difficulties that led to your seeking treatment (or this evaluation):

HISTORY OF PRESENTING PROBLEM:

Describe when your problem(s) began and any information about the pattern of your difficulties (Symptoms, onset, duration of symptoms, frequency, etc.).

PAST PSYCHIATRIC HISTORY:

- Describe how you have attempted to solve or cope with your problem(s). What has worked in the past?

- Other than your current difficulties, have you ever dealt with emotional or mental health problems in the past?
If YES, describe (when, what were the difficulties; if previously diagnosed, what were the diagnoses?):

- Have you ever received OUTPATIENT mental health care in the past? YES NO
○ If YES, to the best of your ability please describe (when and with whom/where)

- Have you ever received INPATIENT or RESIDENTIAL mental health care in the past? YES NO
○ If YES, to the best of your ability please describe (when and with whom/where)

- What has been effective for you in past treatments? [e.g., past effective medications, types of therapy]
 - What has NOT been effective [or medication side-effects]?

- If you were in treatment in the past, what will you do the same and differently to address problems than you did in earlier treatment? That is, what did you do that was effective and ineffective in past treatment?

- Have you ever attempted suicide or self-injurious behavior in the past? YES NO
 - If YES, describe circumstances of past attempts? (e.g., what was going on - thoughts, feelings, situation - before the attempt and your reaction afterward? What did you do?)

TRAUMA HISTORY:

- Have you ever experienced a traumatic event? YES NO
 - If yes, please describe and describe the current impact of this experience (symptoms, growth, change).

- Did you experience any of the following in your lifetime? If yes, please provide information (age of occurrence, persons involved, etc.) or discuss during intake session to the degree you are comfortable.

Physical Abuse Sexual Abuse Emotional Abuse

Witnessed Severe Injury or Accident involving others

Other: _____

FAMILY PSYCHIATRIC AND SUBSTANCE USE HISTORY:

- Does any member of your family suffer from . . . (if yes, indicate relationships)
 - Alcoholism
 - Drug Abuse
 - Anxiety
 - Depression
 - Suicide (attempted or committed)
 - anything else that might be considered a “mental disorder”

MEDICAL CONDITIONS & HISTORY:

- Briefly describe medical issues (current & past).
- What medications do you take for the above problems? (current and past, degree of benefit)
- Indicate if you tend to be tired, drowsy, anxious or agitated on these medications (or other mental health problems you attribute to your medications or medical conditions).
- Briefly describe your view of your overall health (current).
- PAIN: Are you experiencing persistent or chronic pain? YES NO

If yes, on a scale of 0 (none) to 10 (severe), how would you rate this during the past week? ____

What do you do that improves your management of pain?

What do you do that tends to aggravate your level of pain?

- NUTRITION: How is your appetite? Good Fair Poor
 - Have you lost or gained more than 10 pounds in the past 3 months? YES NO
 - If yes, was this desired or intentional? YES NO
 - Have you been eating poorly due to a change in appetite? YES NO
 - Are you on a special diet for medical problem? YES NO

CURRENT MEDICATIONS:

Please list any current medications, including dosage, purpose and name of prescribing physician.

SUBSTANCE USE

- Briefly describe your use of alcohol or other substances:
- In the past have you had problems with the use of alcohol or other substances? YES NO
 - If YES, describe (what were the difficulties, what substances used)

FAMILY HISTORY

Childhood – Adolescence History:

- Where did you grow up?
- Who raised you and between what years?
- Give an impression of your home atmosphere (for example, strict, lenient, calm, tense, chaotic, abusive)
- Do you have siblings (if yes, first names and estimated ages).
- What were and are currently are your relationships like with the above family members?

CHECK any of the following that applied during your childhood / adolescence.

- | | | |
|--|--|--|
| <input type="checkbox"/> Happy Childhood | <input type="checkbox"/> School Problems | <input type="checkbox"/> Medical Problems |
| <input type="checkbox"/> Unhappy Childhood | <input type="checkbox"/> Family Problems | <input type="checkbox"/> Behavior Problems |

- Indicate any significant events or experiences in childhood (prior to age 18):

SOCIAL HISTORY

- Relationship Status: _____ How long together? _____

If in a relationship, please provide his/her *First Name*: _____

If in a relationship, what are some of the things you have enjoyed doing together in past?

What do you do now to maintain the relationship?

- If you have children, please give their first names, ages, and what your relationship is like with him/her:
- Indicate any losses which you have experienced over the past few years (e.g., loved ones, work, pets, etc.):

Peer group:

- Describe what you consider to be your peer group/friends growing up?

- In a few words, describe what you consider to be your current peer group/friends?

- How do you make and maintain friendships?

- Briefly describe your relationships with friends and acquaintances.
 - Closest Friend (first name): _____
 - Activities enjoyed: _____
 - Frequency of contact: daily, weekly, monthly, few times per year (circle one)

 - Other friends – rough number: _____
 - Common Activities enjoyed: _____
 - Frequency of contact: daily, weekly, monthly, few times per year (circle one)

- What do you like most and least about current relationships (or desire more or less from)?

DEVELOPMENTAL HISTORY:

To your knowledge, did you meet developmental milestones on time (walking, talking, etc...)?
[or has your mother or father told you that you had any medical or social problems before gradeschool?]

EDUCATIONAL / OCCUPATIONAL HISTORY:

Education: What was the last grade you completed (degree)? _____

- What do you consider to be your strengths and weaknesses academically / in school / intellectually?

- What were your learning preferences (e.g., reading, verbal instruction, demonstration, visual aids/cues)?

Military Service History:

Branch of Service (circle): None Army Navy Air Force Marines Coast Guard

When did you serve? (range by months & years): From: _____ To: _____

What were your duty assignment(s) / MOS (for example, 11B – infantry): _____

- If frequently tasked outside of duty assignment, please also describe those duties

If deployed, where, when and what were your experiences? If SC, for what injuries and related to what experiences?

What type of discharge did you receive?

Employment History:

- Describe your current or most recent work / profession:

- What other types of work have you done?

- What have you found enjoyable about your work? What do you find unenjoyable?

- If your problems have interfered with work, describe impact on work or work relationships.

LEGAL HISTORY:

Describe your legal history and/or any significant interactions with law enforcement.

STRENGTHS & LIMITATIONS:

PERSONAL STRENGTHS: What are some of the talents or skills that you feel proud of? Try to identify 3.

Limitations or Weaknesses: What would you identify?

OTHER INFORMATION:

This section of items reflects a range of areas that can be used to help build your treatment plan, as well as identify less common but equally important areas of concern.

Sexual History / Concerns:

- Do you have any sexual concerns (currently or in past)? YES NO
If yes, please describe:

Leisure & Recreation:

- How is your free time spent? [hobbies, interests, etc...]. How often do you do these activities?

- What hobbies or activities did you used to enjoy that you wish you were doing again?

Values and Beliefs:

What matters to you in your life? What is important or your priorities? (e.g., family, work, spirituality, values, pets, friends, health, personal growth, activities, nature, hobbies)

What brings you a sense of joy and happiness? (e.g., If nothing now, what have you enjoyed in the past or would like to enjoy in the future? What have you enjoyed in the past that you would like to enjoy again? Where do you go to find a sense of comfort, security, safety or peace?)

Include any additional information you believe would be helpful in understanding your difficulties in space below or attach additional page(s). Usually, additional information is not needed or will be obtained in interview.