Trellis COUNSELING
providing therapeutic support for growth and change

PERSONAL HISTORY FORM

Client name: _____Age: _____ D.O.B. _____ Gender: M F
Primary reason(s) for seeking services:

	Depression		Anxiety		Alcohol/drugs		Anger management
	Coping		Fear/phobias		Behavior problems		Martial issues/conflict

Other_____

Please check behaviors and symptoms that are problematic:

	Aggression		Worrying		Hallucinations		Attention Deficit
	Anxiety		Heart Palpitations		People avoidant		Trouble concentrating
	Depression		Recurring thoughts		Disorientation		Sexual problems
	Alcohol problems		Irritability		Cyber addiction		Antisocial behavior
	Fatigue/Tired		Impulsivity		Speech problems		Sleep problems
	Panic attacks		Distractibility		Gambling problems		Fears/phobias
	Anger		Chest pain		Sick often		Self injury/behavior
	Hopelessness		Loneliness		Alcohol/Drug issues		Memory problems
	Suicidal thoughts		Mood swings		Eating issues		Withdrawing/isolating

Do you feel suicidal at this time? Yes or No Do you have a plan if you are suicidal? Yes or No
Briefly describe how the symptoms impair your ability to function effectively.
_____
_____

Please include any additional information that would assist us in understanding your concerns and problems:
_____
_____
_____

Have you recently experienced any that follow?

	Recent death or birth in the family		Accident, fire, disaster		Separation or divorce
	Job loss or change		Arrest or DUI		Major Financial problems
	Change in living arrangements		Physical/emotional abuse		Sexual abuse or assault
	Thoughts/acts of violence to others		Thoughts/acts of hurting self		Custody issues
	Pregnancy, miscarriage, abortion		Diagnosis of major illness		Significant relationship discord

Parental Information

	Parents legally married		Parents never married		Parents divorced (*your* age at divorce:____)

Special circumstances (e.g., raised by person other than parents, information about spouse/kids not living with you etc.):_____
_____

Marital status

Single Years living together ____ Years legally married ____ Years widowed _____
Divorcing Months separated _____ Years divorced _____ Number of marriages ____
Assessment of current relationship: good fair poor abusive

Developmental history

Has there been a history of child abuse? Yes or No If yes, which type: ___ Sexual ___ Physical ___Verbal
Other childhood issues: ___Neglect ____Exposure to trauma ____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain_____

Social Relationships

Circle how you generally get along with other people:
Affectionate Aggressive Avoidantfight/argue often Follower
Friendly Leader Outgoing Shy/withdrawn Submissive
What is your sexual orientation? _____
Have you experienced any Sexual dysfunctions? Yes or No

Spiritual/Religious

Are you connected with a spiritual or religious group? Please explain_____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Are you involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges _____
Are you currently on probation or parole? Yes or No
Have you been accused of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education: Currently enrolled in school High school grad/GED Vocational school
Some College College Graduate Masters or Doctorate

Any learning disabilities: Yes or No If yes, please explain _____
Employment: Current employer _____
Fulltime Part time Temp Laid-off Disabled Retired Social Security
Job satisfaction: poor good fair great

Military experience? Yes or No Combat experience? Yes or No
Where: _____ Branch: _____ Type of discharge _____ Service length _____

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 sports, etc.)

_____
_____

Medical/Physical Health

Primary care Doctor _____ phone _____
List any current health conditions you have and any recent health changes:_____
Are you currently using any prescribed medications:_____
Please circle if there have been any changes in the following:

Sleep patterns	Eating patterns	Behavior	Energy level	Physical activity level
General disposition	Weight	Nervousness/tension		

Others: _____

Chemical Use History

Do you use drugs and alcohol?: Yes No
How does use affect your life? _____
Has anyone expressed concern about use? Yes No
Are you concerned about use? Yes No
Is there present or past history of a family member having problems with drugs or alcohol? Yes No
Consequences experienced because of use? Legal, Relational, physical, mental, job, financial
Please Explain: _____
_____

Counseling Prior treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care				
Suicidal thoughts/attempts				
Drug/alcohol treatment				
Hospitalizations				

Is there a family history of mental illness or substance abuse problems? _____

Please list treatment goals wished to accomplish.

_____
_____
_____