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ADULT PERSONAL HISTORY

Please provide the following information and bring to your first session. Note: this information is protected and is confidential.

Client's name: _____ Today's date: _____
 Gender: F M Date of birth: _____ Age: _____
 Form completed by (if someone other than client): _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone (home): _____ (work): _____ ext: _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:
 Anger management Anxiety Coping Depression
 Eating disorder Fear/phobias Mental confusion _____
 Sexual concerns
 Sleeping problems Addictive behaviors _____ Alcohol/drugs
 Other mental health concerns (specify): _____

Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Marital Status (more than one answer may apply)

Single together
 Divorce in process
 Unmarried, living together
 Legally married
 Separated
 Divorced
 Widowed
 Annulment
 Length of time: _____ Length of time: _____ Length of time: _____
 Length of time: _____ Length of time: _____ Total number of marriages: _____

Assessment of current relationship (if applicable): Good _____
 Fair _____ Poor _____

Do you have children?
 Names and ages of children _____

Parental Information

Parents legally married
 Number of times: _____ Mother remarried:
 Parents have even been separated
 Number of times: _____ Father remarried:
 Parents ever divorced
 Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

Are there special, unusual, or traumatic circumstances that affected your development?
 _____ Yes No

If Yes, please describe: _____

Has there been history of child abuse? Yes _____
 No

If Yes, which type(s)? _____ Sexual Physical _____
 _____ Verbal

If Yes, the abuse was as a: _____ Victim _____
 _____ Perpetrator

Other childhood issues: Neglect Inadequate nutrition
 Other (please specify): _____
Comments re: childhood development: _____

Social Relationships

Check how you generally get along with other people: (check all that apply)
 Affectionate Aggressive Avoidant Fight/argue often Follower
 Friendly Leader Outgoing Shy/withdrawn
Submissive
 Other (specify): _____
Sexual orientation: _____
Comments: _____
Sexual dysfunctions? Yes _____
No
If yes, describe: _____
Any current or history of being a sexual perpetrator? Yes _____
No
If Yes, describe: _____

Cultural/Ethnic

To which cultural or ethnic group, if any, do you belong? _____
Are you experiencing any problems due to cultural or ethnic issues? _____
Yes _____ No
If yes, describe: _____
Other cultural/ethnic information: _____

Spiritual/Religious

How important to you are spiritual matters? Not Little Moderate
Much
Are you affiliated with a spiritual or religious group? Yes _____
No
If Yes, describe: _____
Were you raised within a spiritual or religious group? Yes _____
No
If Yes, describe: _____
Would you like your spiritual/religious beliefs incorporated into the counseling? _____
Yes _____ No
If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? _____
Yes _____ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ___ Yes _____

No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: _____ Yes _____ No Civil

involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply: Years of education: _____ Currently
enrolled in school? _____ Yes _____ No

___ High school grad/GED

___ Vocational: Number of years: ___ Graduated: ___ Yes _____

No Major: ___

___ College: Number of years: ___ Graduated: ___ Yes _____

No Major: ___

___ Graduate: Number of years: ___ Graduated: ___ Yes _____

No Major: ___

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history: _____

Employer	Dates	Title	Reason left the job	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: ___ FT ___ PT ___ Temp ___ Laid-off _____ Disabled _____

Retired

___ Social Security _____ Student _____

_ Other (describe): _

Military

Military experience? _____ Yes _____ No
 Combat experience? _____
 Yes _____ No _____

Where: _____

Branch: _____ Discharge date: _____

Date drafted: _____ Type of discharge: _____

Date enlisted: _____ Rank at discharge: _____

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, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abortion diseases | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten			
Breakfast	___ / week	_____	___ No	___ Low	___ Med	___ High
Lunch	___ / week	_____	___ No	___ Low	___ Med	___ High
Dinner	___ / week	_____	___ No	___ Low	___ Med	___ High
Snacks	___ / week	_____	___ No	___ Low	___ Med	___ High

Comments: Some days I have no appetite.

Current prescribed medications effects	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds effects	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? ___ Yes _____ No

If Yes, describe: _____

Name of personal physician _____

Physician's address _____

Physician's phone _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _____

Plases check if there have been any recent changes in the following:

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

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	
Barbiturates	_____	_____	_____	_____	_____	_____	_____	
Valium/Librium	_____	_____	_____	_____	_____	_____	_____	
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	
Marijuana	_____	_____	_____	_____	_____	_____	_____	
PCP/LSD/Mescaline	_____	_____	_____	_____	_____	_____	_____	
Inhalants	_____	_____	_____	_____	_____	_____	_____	
Caffeine	_____	_____	_____	_____	_____	_____	_____	
Nicotine	_____	_____	_____	_____	_____	_____	_____	
Over the counter	_____	_____	_____	_____	_____	_____	_____	
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	
Other drugs	_____	_____	_____	_____	_____	_____	_____	

Substance of preference

1. _____
2. _____
3. _____
4. _____

Substance Abuse Questions

Describe when and where you typically use substances: _____

Describe any changes in your use patterns: _____

Describe how your use has affected your family or friends (include their perceptions of your use): _____

Reason(s) for use:

Addicted Build confidence Escape Self-medication
 Socialization Taste Other (specify): _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? Yes No

If Yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (describe): _____

Does your body temperature change when you drink? Yes _____
No

If Yes, describe: _____

Have drugs or alcohol created a problem for your job? Yes _____ No

If Yes, describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	_____	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	_____	_____	_____	_____	_____

Information about family/significant others (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
Involvement with self-help groups (e.g., AA, Al-Anon, NA, Overeaters Anonymous)	___	___	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist us in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? ____ Yes _____ No

If Yes, explain: _____
