Personal History Form: Adult/Teen
Roma Palcan, PhD.

Client's
Name:_____Date:_____

Date of Birth:_____-_____-_____ Age:
_____SS#_____-_____-_____

Address:_____ City:_____
State:____Zip:_____

Cell Phone:_____-_____-_____ Home Phone: _____-_____-_____

Work Phone:_____-_____-_____ Extension:_____

Primary Reason(s) for seeking services

____Anger Management ____Anxiety ____Coping ____Depression ____Eating Issues

____Fear/Phobia ____Confusion ____Sexual Concerns ____Sleep Problems

____Addictive Behavior ____Trauma History Other(please specify)_____

Explain:_____
_

Relationship	**Name**	**Age**	Living? **Yes No**	Living with you? **Yes No**
Mother	_____	_____	__ __	__ __
Father	_____	_____	__ __	__ __
Spouse/Partner	_____	_____	__ __	__ __
Children	_____	_____	__ __	__ __
	_____	_____	__ __	__ __
	_____	_____	__ __	__ __

_____ _____ __ __ __ __

Other Important Relationship(s)

_____ _____ _____ __ __ __ __

_____ _____ _____ __ __ __ __

Development

Are there special, unusual, medical, or traumatic circumstances that affected your development? __Yes __No

If Yes, please describe:_____

Abuse? __Yes __No

If yes, what type(s)? __Emotional __Verbal __Physical __Sexual
__ Exposed to Alcohol/Drug Use ___ Exposed to Violence
__Other (describe_____)

Legal Status

Are you involved in any active cases(divorce, child custody, civil, criminal, traffic)? __Yes __No

Are you presently on probation or parole? __Yes __No

If yes, please describe:
_____

Employment

Occupation:_____

____Employed: ____Full Time ____Part Time

____Disabled ____Retired

Education

Highest level of education:_____

Any learning challenges? If yes, describe::_____

Medical/Physical Health
List any current health concerns:
_____
_____
__

Current Medications (prescribed and over the counter):

Name	Dose	Purpose	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Military? __Yes __No

Branch:_____

Years of Service:_____

Military Job(s):_____

Service Connected
Disability(s):_____

Combat Zone**?** __Yes __No

Prior Mental Health Treatment

	Yes	No	When	Where	Result
Individual Counseling _____	___	___	_____	_____	
Family/Couple _____	___	___	_____	_____	
Drug/Alcohol Treatment _____	___	___	_____	_____	
Psychiatric Hospitalization _____	___	___	_____	_____	
From Medical Doctor _____	___	___	_____	_____	
Pastoral Counseling _____	___	___	_____	_____	

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

___Loss of Interest ___Elevated Mood ___Intense Fear ___Loneliness
___Fatigue ___Recurring Thoughts ___Anger ___Hopelessness
___Stress ___Antisocial Behavior ___High Blood Press ___Aggression
___Heart Palpitation ___Sexual Addiction ___Heart Palpitation ___Pain
___Impulsivity ___Cyber Addiction ___Depressed Mood
___Judgement Errors
___Speech Problems ___Disorganized Thoughts ___Chest Pain ___Low Self Esteem
___Irritability ___Distractibility ___Memory Problems ___Sleep Disturbance
___Disorientation ___Dizziness ___Worry ___Trembling
___Panic Attacks ___Suicidal Thoughts
(describe)_____
___Other(specify)_____
___

Health Behaviors:

Tobacco/E-Cig Use: ___Yes ___No

Which areas in your life do you want to improve?

___Stress Management
___Sleep
___Exercise
___Eating
___Striving for a Healthy Weight
___Reducing Alcohol
___Relationships

What do you want to achieve in counseling?

_____
____

_____
____

_____
____