

**HERON RIDGE ASSOCIATES, PLC
ADULT PERSONAL HISTORY**

Please fill out this form completely as possible. If question does not apply, mark 'N/A'

Client Name: _____ Birthdate: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home): _____ Work/Cell: _____

How were you referred to us _____

Reason for seeking treatment: _____

Please check any of the following that describe how you feel:

- sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless
 annoyed

Describe any other feelings you have had: _____

FAMILY INFORMATION

	Name	Sex	Age	Lives	With You
				Y	N
Spouse/Significant Other/Partner					
Children					
Mother					
Father					
Siblings/Others					

PARENTAL INFORMATION

Children not listed or not living with you: _____

Special Circumstances (e.g. Raised by someone other than parent, adoptions, etc.) _____

ADULT MARITAL HISTORY

Your Current Relationship Status: Single Married Divorced
 Separated Widowed Partnership

If female, your maiden name: _____

Your First Marriage/Partnership: _____ / _____ / _____ / _____
 Age Date No. of Children If divorced, give date

Your Second Marriage/Partnership: _____ / _____ / _____ / _____
 Age Date No. of Children If divorced, give date

Check the best description of your relationship with your present significant other:

Excellent Good Fair Poor

Issues that affected your development: (physical or sexual abuse, nutrition, illness, neglect, etc.)

If Parents Divorced: Your age at the time: _____ Describe how it affected you at the time: _____

What gives you most joy or pleasure in your life: _____

What are your main worries and fears: _____

What are your most important hopes and dreams: _____

SOCIAL INFORMATION

Social time is usually spent Alone Immediate Family Peers

Please describe: _____

Do you isolate yourself from other people? _____

CULTURAL/ETHNIC/RACIAL BACKGROUND

What is the ethnic/racial group of your parents? (Hispanic, African American, etc.) _____

Do you identify with this same group, or another? Yes No Please explain: _____

SPIRITUAL/RELIGIOUS BACKGROUND

Were you raised in a home that practiced religion? Yes No

If 'Yes' which religion: _____

Do you consider yourself a religious person? Yes No

Do you practice a formal religion now? Yes No

If 'Yes' which religion: _____

Do you consider yourself to be a spiritual person? Yes No

LEGAL INFORMATION

Have you ever been involved with the police or the courts? Yes No

If 'Yes' please specify

CHARGE	DATE	RESULTS	WAS THIS RELATED TO ALCOHOL OR OTHER DRUG USE

Are you presently on probation or parole? Yes No

If 'Yes please explain: _____

MILITARY SERVICE

Have you ever served in the armed forces? Yes No

Branch: _____ Enlistment Date _____ Discharge Date _____

Rank: _____ Combat Experience: Yes No

If 'Yes' where/when? _____

EDUCATION

Highest grade completed? _____ High School Diploma G.E.D.
 Attend Night School Some College
 College Degree Graduate Degree

List any vocational training you have had: _____

Are you satisfied with your education? Yes No

If 'No' why not? _____

EMPLOYMENT/VOCATIONAL

Are you currently employed? Yes No Homemaker

EMPLOYERS (Most recent first)	DATES	JOB DESCRIPTION	SALARY

Special circumstance (laid off, medical leave, suspended, retired, etc.) _____

Total Yearly Income: \$ _____ Total Family Income: \$ _____

Do you currently have financial problems? Yes No

If 'Yes' please explain _____

LEISURE/RECREATIONAL

List your hobbies, leisure time activities, interests _____

Has your level of activity changed? Yes No If 'Yes' please explain _____

Do you participate in regular exercise? Yes No Please Describe: _____

How much time do you spend online or gaming? _____

COUNSELING/PRIOR TREATMENT HISTORY

Have you had psychotherapy/counseling before? Yes No If 'Yes' Where:

NAME OF CENTER

DATES ATTENDED

1. _____

Type of service: Outpatient Inpatient Day Treatment

Was this for alcohol or other drug use? Yes No

Why did you stop going to therapy? _____

NAME OF CENTER

DATES ATTENDED

2. _____

Type of service: Outpatient Inpatient Day Treatment

Was this for alcohol or other drug use? Yes No

Why did you stop going to therapy? _____

Do you attend "A.A" or "N.A"? Yes No How Often? _____

Do you attend any other support groups? Yes No

If 'Yes' please describe _____

Have you had any change in sleeping habits? Yes No Describe: _____

Have you had any change in eating habits? Yes No Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? Yes No

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the past? Yes No

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? Yes No

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? Yes No

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? Yes No

If Yes, please explain: _____

CHEMICAL USE HISTORY

Please check any of the following risk-taking behaviors you have engaged in:

___ street racing ___ gang involvement ___ skip school ___ dropped out ___ dangerous dieting ___ cutting ___ stealing
___ unprotected sex ___ running away ___ bullying others ___ fire starting ___ hurt animals ___ over exercise
___ restrict or restricted food intake

Please check any of the following alcohol /drugs that you currently or have previously used:

LSD Spice beer wine hard liquor pot cocaine heroin Ecstasy speed
 over the counter drugs prescription drugs ice Triple C's dones quad bars Special K

SUBSTANCE	METHOD OF USE AMOUNT	AGE OF FIRST USE	AGE OF REG USE	AGE OF LAST USE	USED IN LAST 48 HRS	USED IN LAST 30 DAYS
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSC/Mesc.						
Inhalants						
Caffeine						
Nicotine						
Over-Counter						
RX Drugs						
Other Drugs						

SUBSTANCE PREFERENCE

1. _____ 2. _____

Describe when and where you typically use _____

Describe any changes in your use patterns: _____

Do you use to build up your confidence? Yes No

Describe who or what has helped you: _____

Who in your family (present/past) has had a problem with drugs or alcohol? _____

Have you had withdrawal symptoms when trying to stop drinking/using? Yes No

Does your temperament change when you drink/use? (describe): _____

Has Alcohol/drugs created a problem for your job? Yes No

If 'Yes' describe: _____

PHYSICAL HEALTH

Your current physician:

NAME	ADDRESS	PHONE NUMBER
_____	_____	_____

Date last seen by your physician: _____

Reason for seeing your physician: _____

Check all that apply and describe below:

- | | | |
|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Eating Problems | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fainting | <input type="checkbox"/> Small Pox |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Other |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nausea | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheum. Fever |

Explain: _____

Current medications being taken:

- 1) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 2) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 3) _____ Dosage/Freq _____ Start Date _____ Purpose _____
- 4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Have you ever been hospitalized for medical or psychiatric reasons? [] Yes [] No

Hospital	Mo / Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Are you currently pregnant () No () Yes, if so obtaining prenatal care? () No () Yes

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relatives (father, mother sister, brother, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

Client Signature: _____ Date: _____

STAFF USE ONLY

Clinician signature/credentials Date

Physical Exam: [] is required [] is not required

M.D/D.O Comments _____

Physicians signature/credentials Date 2014