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

Any history of sexual assault? ( ) No ( ) Yes, explain_____

_____

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? _____

_____

Who do you naturally reach out to for support or help?_____

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	DATES	JOB DESCRIPTION	SALARY
(Most recent first)			

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:

[ ] Aids
[ ] Alcoholism
[ ] Abdominal Pain
[ ] Allergies
[ ] Anemia
[ ] Appendicitis
[ ] Arthritis
[ ] Asthma
[ ] Bronchitis
[ ] Bed Wetting
[ ] Cancer
[ ] Chest Pain
[ ] Chronic Pain
[ ] Colds/Coughs
[ ] Constipation
[ ] Chicken Pox
[ ] Diabetes
[ ] Drug Abuse
[ ] Diarrhea
[ ] Epilepsy
[ ] Ear Infections
[ ] Eating Problems
[ ] Fainting
[ ] Fatigue
[ ] Frequent Urination
[ ] Headaches
[ ] Hearing Problems
[ ] Hepatitis
[ ] High Blood Pressure
[ ] Kidney Problems
[ ] Measles
[ ] Mononucleosis
[ ] Mumps
[ ] Menstrual Pain
[ ] Neurological Disorder
[ ] Nausea
[ ] Nose Bleeds
[ ] Pneumonia
[ ] Sore Throat
[ ] Scarlet Fever
[ ] Sinusitis
[ ] Small Pox
[ ] Stroke
[ ] Sexual Problems
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Toothache
[ ] Thyroid Problems
[ ] Vision Problems
[ ] Venereal Disease
[ ] Vomiting
[ ] Whooping Cough
[ ] Other
[ ] Sleep Problems
[ ] Dental Problems
[ ] Dizziness
[ ] 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 2017