Alpha Psychological Services, P.C.

PERSONAL HISTORY INFORMATION

Name _____ Age _____ Birth Date _____

Address _____ City _____ Zip Code _____

Phone (work) _____ (home) _____ (cell) _____

Marital Status: (circle one) Married Single Divorced Widowed

Spouse/Partner _____ Age _____

Family History

	Father	Mother
Name		
Ages		
Highest grade level		
If deceased, dates		
Where do they live?		
If divorced - date (year - your age)		
If divorced/deceased, has either/both remarried?		
Step Parent(s) Name(s)		

Brothers/Sisters Names	Age	Sex	Occupation	Where living?	Deceased?

Children Names	Age	Sex	School & Grade	Lives at home?	Step?

Religious History: Do you attend a church? _____ Name of church _____ Family religious background? _____

Legal: Do you have any legal cases pending? _____ Are you on probation? _____ If yes, court district _____
Any traffic violations in the past year? _____
Have you had any legal cases in the past? _____

Personal History: Have you ever been a victim of: _____ sexual abuse
_____ physical abuse _____ verbal/emotional abuse
Who was the abuser(s) _____
Have you ever abused anyone?
_____

Social History: How many close friends do you have? _____
How well do you get along with co-workers? _____
What do you like to do socially? _____

Education: Highest grade achieved _____
Name of college/vocational school _____
Date of graduation _____ Degree _____
Graduate or Professional school _____

Employment: Current employer _____
Been here for _____ years Duties _____

Military: Served in military? _____ Branch _____
Discharge date _____ Active duty? _____
Type of discharge _____
Has your spouse/partner/parent served in the military? _____
If so, approximately when and what branch? _____

Medical History: Physician _____ City _____
Last seen (approx. date) _____ for _____
Taking any prescription medication?
For _____ Medication _____ Dosage _____ Since _____
For _____ Medication _____ Dosage _____ Since _____
For _____ Medication _____ Dosage _____ Since _____
Side effects? _____
Any on-going medical conditions? _____

Previous Mental Health Treatment:
Have you seen a counselor before? _____ How long ago?
_____
Location _____ How many sessions? _____
Was the treatment helpful for you? _____
At that time, sought treatment for _____
Any other family members in counseling? _____

Substance Abuse/Drugs: Have you used drugs/alcohol in the past week? _____
Past month? _____ Type _____ Amount _____
Has alcohol/drug use ever caused a problem? _____
Please explain _____
Have you ever been treated (residential/out-patient) for substance abuse? _____
Where and when _____
Have you ever attended a 12-Step Program?
_____
Parents or grandparents with alcohol/addiction problems? _____
Siblings with alcohol/drug/addiction problems? _____

Daily Routine: How well do you sleep? _____ Fall asleep OK? _____
Stay asleep? _____ Feel rested in AM? _____
Usually how many hours of sleep do you get per night? _____
Any changes in last six months? _____
How is your appetite? _____
Any changes in last six months? _____
Weight loss in last year? _____ Gain? _____
Energy level during the day? _____
Does your life feel sufficiently organized? _____
Do you currently have any homicidal thoughts? _____
Do you currently have any suicidal thoughts?
_____

Anything else you feel would be helpful for your counselor to know? (If additional space is needed, please use reverse side of this sheet.)

Signature: _____ Date: _____