BiofeedbackWORKS in Virginia PLLC

PERSONAL HISTORY - ADULT

Client Name: _____ Date: _____

Gender: ___ F ___ M Date of Birth: _____ Age: _____

Form completed by (if someone other than client): _____

If you need more space to answer any question, 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 concerns *(Please specify):* _____

Medical/Physical Health

____ Alcoholism
____ Allergies
____ Cancer
____ Chest pain
____ Chronic pain
____ Constipation
____ Dizziness
____ Drug abuse
____ Epilepsy
____ Fatigue
____ Headaches
____ Hearing problems
____ High blood pressure
____ Neurological disorders
____ Sleep apnea
____ Snoring
____ Sleeping disorders
____ Sexual problems
____ Vision problems

___ Other (describe): _____

_____

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects

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

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

If Yes, describe: _____

	DATE:	REASON:	RESULTS:
Last physical exam			
Last doctor's visit			
Most recent surgery			
Other surgery			
Upcoming surgery			

Family history of medical problems: _____

_____

Please 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: _____

Family Information

RELATIONSHIP	NAME	AGE	Living YES	Living NO	Living with you YES	Living with you NO
Mother						
Father						
Spouse						
Children						

SIGNIFICANT OTHERS (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

RELATIONSHIP	NAME	AGE	Living YES	Living NO	Living with you ? YES	Living with you ? NO

MARITAL STATUS (more than one answer may apply)

___ SINGLE

___ LEGALLY MARRIED How long? _____

___ UNMARRIED How long? _____

___ WIDOWED How long? _____

___ SEPARATED How long? _____

___ DIVORCE IN PROGRESS How long? _____

___ DIVORCED How long? _____

___ ANNULMENT How long? _____

Total number of marriages: _____

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

PARENTAL INFORMATION

___ Parents legally married

___ Parents have been separated

___ Parents ever divorced

___ Mother remarried: Number of times: ____

____ Father remarried: Number of times: ____

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: _____

Comments about childhood development: _____

_____

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): _____

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?

Chemical Use History

Please list any substances that you use or have used in the past: (e.g.,. alcohol, marijuana, cocaine, etc.)

Substance	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours? YES	Used in last 48 hours? NO	Used in last 30 days? YES	Used in last 30 days? NO
Heroin/Opiates								
Other drugs								

Substance Abuse Questions

Describe any changes in your use patterns: _____

_____

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): _____

_____

Counseling/Prior Treatment History

Information about client (past and present):

EXPERIENCE	YES	NO	WHEN	WHOM	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	WHOM	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:

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

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 _____

- For Staff Use -

Therapist's comments: _____

Therapist's signature/credentials: _____ Date: ___ /____/_____