BiofeedbackWORKS in Virginia PLLC

PERSONAL HISTORY - ADULT

Client Name: ..... Date: .....

Gender: ..... 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.

Official diagnosis: .....

Diagnosed by: .....

Primary reason(s) for seeking services: .....

.....

What would you like to achieve from therapy? .....

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Have you had a sleep study? __Yes __No

If yes what were the results? .....

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Psychological/Behavioral Concerns

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

___ Aggression
___ Alcohol or drug concerns
___ Anxiety
___ Bizarre thoughts
___ Depressed mood
___ Easily distracted
___ Eating patterns
___ Focus
___ Gambling concerns
___ Grief/loss
___ Hallucinations
___ Hopelessness
___ Impulsivity
___ Internet/gaming concerns
___ Intrusive thoughts
___ Irritability
___ Loneliness/isolation
___ Low motivation
___ Obsessive/Compulsive Thoughts
___ Extreme elevated mood (mania)
___ Memory and/or concentration problems
___ Mood swings
___ Panic attacks
___ Phobias/fears
___ Procrastination
___ Self-esteem
___ Self-harm/self-injury
___ Sexual concerns
___ Speech problems
___ Trauma/PTSD
___ Too much/too little sleep
___ Trembling
___ _____
___ _____
___ _____

Please discuss briefly how the above symptoms impair your ability to function effectively: .....

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Please check any recent changes in the following:

___ Sleep patterns
___ Physical activity level
___ Pain (head/body)
___ Eating patterns
___ General mood
___ Behavior
___ Weight
___ Energy level
___ Nervousness/tension

Describe selected changes: .....

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Prior Treatment History

Information about client (past and present)

		When	Provider	Overall Experience
Counseling/Psychotherapy	__Yes __No	.....	.....	.....
Psychiatric hospitalizations	__Yes __No	.....	.....	.....
Suicidal thoughts/attempts	__Yes __No	.....	.....	.....
Drug/alcohol treatment	__Yes __No	.....	.....	.....
Involvement with self-help groups (e.g. AA, NA, Al-Anon)	__Yes __No	.....	.....	.....

Do you currently have thoughts of harming yourself? __Yes __No

If yes, please explain: .....

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.....

Information about family (past and present)

		When	Family Member	Overall Experience
Counseling/Psychotherapy	__ Yes __No	.....	.....	.....
Psychiatric hospitalizations	__ Yes __No	.....	.....	.....
Suicidal thoughts/attempts	__ Yes __No	.....	.....	.....
Drug/alcohol treatment	__ Yes __No	.....	.....	.....
Involvement with self-help groups (e.g. AA, NA, Al-Anon)	__Yes __No	.....	.....	.....

Family history of medical issues: .....

.....

Family Information

	Name	Living	Living with you
Mother:	.....	__Yes __No	__Yes __No
Father:	.....	__Yes __No	__Yes __No
Spouse:	.....	__Yes __No	__Yes __No

	Name	Living	Living with you
Children:	.....	__Yes __No	__Yes __No
	.....	__Yes __No	__Yes __No
	.....	__Yes __No	__Yes __No
	.....	__Yes __No	__Yes __No
	.....	__Yes __No	__Yes __No

	Name	Living	Living with you
Significant	.....	__Yes __No	__Yes __No
Others:	.....	__Yes __No	__Yes __No
	.....	__Yes __No	__Yes __No

How would you describe your relationship with the people that you live with (e.g. supportive, strained)?

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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: .....

Medical or Physical Concerns

Indicate any history of the following concerns:

___ Allergies
___ Cancer
___ Chemotherapy/ radiation
___ Chest pain
___ Concussion
___ Constipation
___ Dizziness
___ EDS
___ Epilepsy/Seizures
___ Fatigue
___ Fibromyalgia
___ Heart palpitations
___ Headaches/migraines
___ Hearing problems
___ High blood pressure
___ Insomnia
___ Irritable bowel syndrome
___ Lyme disease
___ Movement disorders
___ Other gastrointestinal concerns
___ PANDAS
___ POTS
___ Sexual difficulties
___ Sick often
___ Sleep apnea
___ Snoring
___ Stroke
___ Surgeries
___ Traumatic brain injury

List any current physical health concerns: .....

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List all currently prescribed medications:

Name:	Dose:	Dates:	Purpose:	Side Effects:

List any over-the-counter medications or supplements you take regularly:

	Date:	Reason:	Results:
Last complete annual check-up:			
Last doctor's visit:			
Surgery history:			

Development

Are there special, unusual, or traumatic circumstances that affected your development, e.g. premature birth, foster care, adoption? __Yes __No

If yes, please describe: .....

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If adopted, what information do you have about your biological parents? .....

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Traumatic Experiences

Have you ever experienced any traumatic events in your lifetime, e.g. car accident, physical assault, sexual abuse, divorce, military combat? __Yes __No

If yes, please describe: .....

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Education

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): .....

Employment History

Current employer: .....

Occupation: .....

Years employed: .....

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?
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Substance Use History

Please list any substances that you currently use or have used (e.g. alcohol, marijuana, cocaine, opiates):

Substance:	Frequency of use:	Age of first use:	Date of last use:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Please describe recent changes in your substance use patterns: .....

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Have you experienced withdrawal symptoms when trying to stop using drugs and/or alcohol? __Yes __No

If yes, please describe: .....

Please describe any family history of substance use: .....

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- For Staff Use -

Therapist's comments:

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