Personal History Form

Name _____ Todays Date _____

Date of Birth _____ Religion / Spirituality _____

Race / Ethnicity _____

Home Address _____ City _____ State_____ Zip code_____

Local Address **(if WCU Student)**_____ City _____ State_____ Zip code_____

Home Phone _____ Ok to leave message? Yes ☐ No ☐

Mobile Phone _____ Ok to leave message? Yes ☐ No ☐

Information for Clients

Your intake consists of a series of questionnaires and an interview lasting about 90 minutes. Rather than focus on a list of questions during your initial interview we prefer to focus on your current problem and how we can help you. Completing this form will help with that process.

Intake Questions

Current living situation Apartment/Rent ☐ Own Home ☐

Do you live alone? Yes ☐ No ☐

If no, please list the names and relationships of the people you live with.

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Please tell us about any concerns you have regarding your current housing situation.

_____

Current Employer _____ Length of Employment _____

Please tell us about any concerns you have regarding your current employment situation.

_____

Primary Physician name and phone number:

_____

Are you attending school? Yes ☐ No ☐ Full-time ☐ Part-time ☐

Name of School _____

Status: Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐

Please tell us about any concerns you have regarding school.

_____

Please tell us your gender.

_____

Please tell us your sexual orientation.

Please tell us any concerns you have regarding your relationship status, gender, or sexual orientation.

Have you ever been told that you have a thyroid problem? Yes ☐ No ☐ Unsure ☐

Do you have a history of: (check all that apply)

Asthma/COPD ☐ Stroke ☐ Chronic Pain ☐ Anemia ☐ Cancer ☐

Difficult pregnancy, labor, or delivery ☐ Ulcers ☐

Do you have any medication or food allergies? Yes ☐ No ☐ Unsure ☐

If yes, please specify: _____

Do you have any current medical conditions? Yes ☐ No ☐ Unsure ☐

If yes, please specify: _____

Do you have any history of concussions / loss of consciousness? Yes ☐ No ☐ Unsure ☐

If yes, when? _____

Do you have any previous psychiatric diagnoses? Yes ☐ No ☐ Unsure ☐

If yes, please specify: _____

Have you ever been hospitalized for any emotional or psychiatric reason? Yes ☐ No ☐ Unsure ☐

If yes, how many times have you been hospitalized? _____

Date	Name of Hospital	Reason for Hospitalization	Was it helpful?

Have you ever received psychiatric or psychological treatment before (e.g. counseling)? Yes ☐ No ☐ Unsure ☐

If yes, please complete:

Date	Name of Clinician	Reason for Treatment	Was it helpful?

Are you taking any medication for psychiatric reasons? Yes ☐ No ☐ Unsure ☐

If yes, please complete:

Medication	Dose	Frequency	Name of Prescriber

Have you ever made a suicide attempt? Yes ☐ No ☐ Unsure ☐

If yes, how many times? _____

Approximate Date	What did you do to hurt yourself?	Were you hospitalized?

Have you ever experienced emotional or verbal abuse as a child? Yes ☐ No ☐ Unsure ☐

Have you ever experienced sexual abuse as a child? Yes ☐ No ☐ Unsure ☐

Have you ever experienced non-sexual abuse as a child? Yes ☐ No ☐ Unsure ☐

Have you ever experienced being raped (including acquaintance and marital rape)? Yes ☐ No ☐ Unsure ☐

Have you ever experienced emotional or verbal abuse as an adult? Yes ☐ No ☐ Unsure ☐

Have you ever experienced non-sexual physical abuse as an adult? Yes ☐ No ☐ Unsure ☐

Have you ever been concerned about your sexual behavior in terms of unusual practices, addiction, high-risk, identity confusion, or other matters?

Yes ☐ No ☐ Unsure ☐

Do you have any criminal history, including arrests and penalties, or are you currently involved in any legal actions?

Yes ☐ No ☐ Unsure ☐

Has anyone in your family ever made a suicide attempt? Yes ☐ No ☐ Unsure ☐

If so, how is this person related to you? _____

Has anyone in your family died from suicide? Yes ☐ No ☐ Unsure ☐

If so, how is this person related to you? _____

Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse, or other addictions?

Yes ☐ No ☐ Unsure ☐

If so, how are these persons related to you, and what is a summary of their problems?

_____

_____

_____

Do you have any concerns in any of the following areas? Check all that apply.

Appetite ☐ Sleep ☐ Concentration / Memory ☐ Energy ☐ Motivation ☐

Physiological symptoms (heart racing, shortness of breath, hands trembling, nausea, etc.) ☐

Ability to enjoy pleasurable activities ☐ Helpless / Hopeless / Worthless ☐ Hearing / Seeing things that others do not see ☐

Paranoia ☐ Other ☐

If other, please specify: _____

Did you complete this form: Independently ☐ -or- With the help of someone ☐

If someone helped you, who was it? _____

Continue onto back for scheduling preferences

Scheduling Preferences

Services Requested (check all that apply): Individual ☐ Couples ☐ Group ☐ Family ☐

Please provide your availability for appointments below:

Monday: _____

Tuesday: _____

Wednesday: _____

Thursday: _____

Friday: _____