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PERSONAL HISTORY INVENTORY

The information requested will be used to help your therapist in your treatment. All information is handled in a manner that protects confidentiality. We appreciate your cooperation and will assist you if any questions are unclear.

General Information

Name of client: _____ Date of Birth: _____

What is the presenting issue(s) that brought the client in today? _____

How long have these issue been bothering the client?
1 week a few weeks 1 month a few months 1 year or more Unknown

What would the client prefer to see happen during session that would effect changes pertaining to these issues?

RECREATION/LEISURE

What does the client do for fun? _____

Who usually is with the client when him/her have fun? _____

Is finding a way to have fun difficult for the client? Yes No

Does the client presently belong to any clubs, groups or organizations? Yes No

Is the client satisfied with his/her current recreational activities? Yes No

What are the client's special interests or talents? _____

Education/Social Interactions

What school is the client currently attending? (if not currently in school, please list the last school attended) _____

Current/last grade: _____ Is/did the client staying within grade level? Yes No

What were the reasons you stopped? _____

If you did not complete High School, have you obtained your GED? Yes No N/A

How many different schools have you attended? _____

Did/do you participate in school activities while you were growing up? Yes No
Which ones? _____

Does it appear the therapist should provide some interaction/assistance with the school? Yes No

What course(s) is/did the client have the most difficulty with? _____

Is the client having behavioral problems at school? Yes No N/A

If yes, Please describe: _____

While in school, has the client (please circle): been retained, received speech therapy, been in special classes, been individually tested, been suspended, or been expelled? Please explain: _____

Does/did the client have difficulty focusing/paying attention in school? Yes No

Does the client have difficulty making friends? Yes No Unknown

Does the client keep friends made? Yes No

How does the client treat friends or social peers? (Aggressive, withdrawn from friends, conflicts [such as hitting, yelling, etc.])

Does the client often interrupt or intrude on others? Yes No

Substance Use/Abuse

Does the client or has the client ever used any illicit drugs, alcohol or tobacco? Yes No Unknown
(If yes, please complete the following information)

Drug of choice	How often	Age/Date First Used	Last Used
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does the client use now, or have you ever used IV drugs? Yes No Unknown

Has the client ever been exposed to alcohol, drugs, or tobacco, but never used them? Yes No Unknown
If yes, please describe: _____

Has the client received mental health or substance abuse services anywhere before (including any hospitalizations)? Yes No

(If yes, please complete the following information)

Facility	Inpatient/Outpatient	Date Admitted	Date Discharged
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical/Physical History

Is the client currently being treated for a medical or surgical condition? Yes No

If yes, please describe: _____

Please list all medications that the client is currently taking, or have taken in the past 6 months:

Medications	Dosage	Purpose Benefits/Difficulties	Side effects	Doctor

Is the client allergic to, or have had an adverse reaction to ANY medications? Yes No

If yes, please describe: _____

Does the client have any other allergies (insect bites, food, etc.)? Yes No

If yes, please describe: _____

Has the client had any changes in:

- Sleeping habits Yes No
- Eating habits Yes No
- Sexual habits Yes No

Please describe: _____

Does the client have any (please circle): language impairment, speech impairment or visual impairment?

Does this client require any assistance with personal care or basic needs? Yes No

Legal/Criminal History

	YES	NO
Does the client often argue with adults?	<input type="checkbox"/>	<input type="checkbox"/>
Is the client able to abide by rules?	<input type="checkbox"/>	<input type="checkbox"/>
Does the client display antisocial behaviors?	<input type="checkbox"/>	<input type="checkbox"/>
Is the client aggressive with others?	<input type="checkbox"/>	<input type="checkbox"/>
Has the client destroyed any property?	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any legal issues this client may have: _____

Developmental/Family/Social

Was there anything unusual about the client's birth and infancy? Yes No

How old were the client's parents when he/she was born? Mother____ Father____

Was the client's pregnancy planned? Yes No Unknown

Describe any complications with the pregnancy of this client (pre/post): _____

Were drugs, medications or alcohol used during the client's pregnancy? Yes No Unknown

Describe: _____

Was the client late/delayed in walking, talking or self care? Yes No Unknown

Describe: _____

During childhood (birth to age 18) did the client have any serious illness or injuries? Yes No

With whom did the client live as a child? (Please list relationships and the ages during which you lived with them; examples may be natural parents, mother, grandmother, foster parents, etc.)

Did the client's family move frequently during his/her childhood? Yes No

Was the client's childhood happy? Yes No

What words would the client use to describe his/her relationship with his/her family during his/her childhood _____

How would the client describe his/her father during his/her childhood? _____

How is the client's relationship with his/her father now? _____

How would the client describe his/her mother during his/her childhood? _____

How is the client's relationship with his/her mother now? _____

Please list the client's brother(s) and/or sister(s) with their ages.

_____	_____	_____
_____	_____	_____
_____	_____	_____

How did/does the client get along with his/her sibling(s) as a child? _____

How did/does the client get along with his/her sibling(s) now? _____

Did/does the client's family activities, while the client was growing, up include other relatives, such as grandparents, aunts, uncles and cousins? Yes No Sometimes

How was/is the client disciplined as a child and adolescent? _____

As an adult, has the client ever been in trouble with the law (other than minor traffic violations)?

Yes No N/A

If yes, please explain: _____

During the client's childhood, was the client ever in trouble with the law? Yes No

If yes, please explain: _____

At what age did the client leave his/her childhood home? _____ N/A

Is there a history of mental illness, alcohol/drug dependence or suicide in the client's family? Yes No

(If yes, please complete the following information)

Family Member	Relationship	Substance/Mental Health	Received Treatment?

Did the client have good friends during his/her childhood? Yes No

Does the client have close friends now? Yes No

Has the client ever been a witness of domestic violence? Yes No

Please describe: _____

Has the client ever been a victim of domestic violence? Yes No

Please describe: _____

Has the client ever been accused of or charged with domestic violence? Yes No

Please describe: _____

Has the client ever served jail time for domestic violence? Yes No

Describe sentence and time served: _____

Has the client ever been a victim of abuse: Yes No

If yes, was it: Physical Sexual Verbal/Emotional

Please list the abuse, age(s) it occurred, and the abuser? _____

CULTURAL/MORAL BELIEFS

Does the client consider himself/herself to be part of any cultural or ethnic group? (examples: Italian, Black, Tribal Indian, etc.) Yes No If Yes, please list: _____

Is there anything about the client’s cultural beliefs of which he/she would like the therapist to be aware?

Yes No Please explain: _____

Does the client consider himself/herself to be a religious person? Yes No

please list religious affiliation: _____

If yes,

How does the client’s religious or cultural beliefs affect his/her life? _____

Is religious or cultural beliefs part of the issue which brings the client here for assistance? Yes No

Where did the client receive his/her moral training? _____

Do the ways the client was trained as a child sometimes cause him/her to feel guilty? Yes No

MARITAL

What is client’s current relationship status?

Single Married Divorced Separated Widowed Living as married Dating

How old was the client when he/she was first married or lived as married? _____ N/A

If not married, please describe the relationship: _____

How long have the clients present or most recent marriage/relationship lasted? _____

Has the client been married or lived as married more than one time? Yes No

If yes, total number of times _____

If married or living as married, does the client and his/her spouse/partner differ in attitudes on any of the following:

Sexual matters Leisure activities Religion Raising children Finances Infidelity

Women's role in the family Man's role in the family Drug/Alcohol Use

Has any of the client's marriages/relationships involved domestic violence/abuse? Yes No

If yes, please explain: _____

Is there anything else about the client's marriage(s), relationship(s) or divorce(s) you would like your therapist to know?

Does the client have children? Yes No N/A

Are they a product of his/her current relationship? Yes No N/A

What are their ages and sexes? N/A

Do the client's children live with him/her? Yes No N/A

SEXUAL

Where did the client learn about sex and sexuality? _____

At what age did the client begin dating? _____

At what age did the client become sexually active? _____ N/A Was it voluntary? Yes No

Is the client sexually active at the present? Yes No
If not, would the client like to be? Yes No

Are sexual problems any part of what brought the client in for therapy? Yes No Don't know

Sexual orientation: _____

Has the client ever had any traumatic sexual experiences? Yes No

If Yes, when: _____

Does the client know if he/she has engaged in any behavior that would put the client at risk for HIV/AIDS or other sexually transmitted diseases? Yes No

If yes, please explain: _____

OCCUPATIONAL

Has the client ever held a job? Yes No

Describe the jobs/chores the client has now: _____

While attending school, did/does the client hold a job? Yes No

At what age did the client begin supporting himself/herself? _____ N/A

What is the client's employment status now? Employed Unemployed Retired Disabled

If currently employed, where does the client work? _____N/A

How long has the client worked there? _____N/A

What does the client do there? _____N/A

How many hours per week does the client usually work? _____N/A

Is the client satisfied with your current employment situation? Yes No N/A

If no, what would the client rather do? _____N/A

How many times during the client's adult lifetime has he/she changed jobs? _____N/A

FINANCIAL (for adults only)

Was there a time since the client has been self-supporting that the client felt more financially secure?

Yes No N/A

Does the client feel he/she has enough money to pay for his/her essential needs? Yes No N/A

MILITARY

Has the client ever served in the military? Yes No (If no, please write NA on lines regarding military service)

Branch of service: _____

Age at enlistment: _____

MOS: _____

Tour of duty dates: _____

Combat duty: Yes No When: _____ Where: _____

Type of discharge: _____

Is there anything important the therapist should know about the client's military experience? Yes No

What services does the client want? _____

Any other comments or information you wish to share: _____

Name of person completing this form: _____

Relationship to client: _____

Date Form Completed: _____