Wellness Solutions, LLC

Danielle C. Ellis, MA, MCJ, LPC, NCC

Personal History Form—Adolescents and Adults

***Please print, fill out, sign at the bottom, and bring to your first session. If you have any questions please let me know and we can discuss them in your first session.*

Date: ______________________________

Client's name:____________________________

Gender: ___ F ___ M

Date of birth:____________ Age: _______

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

Address: ____

City:______________ State: __________ Zip: _____

Phone (home): ______________

Is it alright to leave a detailed voicemail at the above contact number? ____________

Cell:____________________

Is it alright to leave a detailed voicemail at the above contact number? ____________

(work): ________________ ext: ________________

Is it alright to leave a detailed voicemail at the above contact number? ____________

Who referred you to Wellness Solutions, LLC? ________________________________

May Wellness Solutions Send a Thank You Letter for referring you? (Your name will not be used in the letter.) ____

Who has the difficulties that you are seeking services for today? _________Self _________Spouse __________Child ________ Family _________ Extended Family Member _________ Other

If more space is needed for any of your answers, please use the space on the last page of this form.

Primary reason(s) for seeking services: (Check all that are applicable in your situation)

__ Anger management ___ Anxiety ___ Coping ___ Depression

__ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexual concerns

__ Sleeping problems ___ Addictive behaviors ___ Alcohol/drugs ___ Marital

__ Other mental health concerns (specify): ________________________________

Your Present Need And Expectations For Services

Please list in your own words why you are seeking Danielle's services today?

____
____
____

What are the three MOST important issues you would like to address in counseling?

____
____
____

What services do you want to receive from Danielle to address the issues listed above:

____
____
____

What made you decide to seek Danielle services now and not at another time?

____
____
____

If a miracle happened and the concerns or problems that you are seeking assistance for were resolved, what positive differences in behavior or situation or personal experiences would you expect to see occurring?

____
____
____

How will you know if the services that Danielle is providing are successful?

____
____
____

Current Family Information

Relationship	Name	Age	Living: Yes	Living: No	Living with you: Yes	Living with you: No
Mother	____	____	____	____	____	____
Father	____	____	____	____	____	____
Spouse	____	____	____	____	____	____
Children	____	____	____	____	____	____
	____	____	____	____	____	____
	____	____	____	____	____	____

Significant others (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
____	____	____	____	____	____	____
____	____	____	____	____	____	____
____	____	____	____	____	____	____
____	____	____	____	____	____	____

Current Marital Status (more than one answer may apply)

__ Single___ Divorce in process ___ Unmarried, living together Length of time: ________________

__ Legally married ___ Separated ____ Divorced

Length of time: _____________ Length of time: ___________ Length of time: _____________

__ Widowed ___ Annulment

Length of time: _____________ Length of time: ___________ Total number of marriages: __

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

Parental Information

__ Parents legally married ____ Mother remarried: Number of times: _______

__ Parents have even been separated ____ Father remarried: Number of times: _______

__ Parents never divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): ____

How many moves did you make with your family as a child? _____________ Did moving create problems for you as a child or adolescent? ____ Yes ____ No Did parental illness create problems for you as a child? ______ Yes _______ No Did parental substance abuse create problems for you as a child or as an adolescent? ____Yes ____No Was there other abuse in your family as a child/teen? _______Yes_____ No

Developmental Information

Are there special, unusual, or traumatic circumstances that affected your development? ___ Yes ___ No

If Yes, please describe: ______________________________

Has there been history of child abuse? __ Yes __ No Child Neglect? _______Yes ______No

If Yes, which type(s)? ____ Sexual ____ Physical __Verbal ______Emotional

If Yes, the abuse was as a: ____ Victim ______ Perpetrator

Other childhood issues: ____ Neglect ___ Inadequate nutrition __ Other (please specify): __________

Comments re: childhood development: ______________________________

____

Social Relationships

Check how you generally get along with other people: (check all that apply)

__ Affectionate ____ Aggressive ____ Avoidant ____ Fight/argue often ____ Follower

__ Friendly ____ Leader ____ Outgoing ____ Shy/withdrawn ____ Submissive

__ Other (specify): ______________________________

Sexual orientation: ________________ Comments: ______________________________

Sexual dysfunctions? ____ Yes __ No Sexual Addiction? _________Yes _____________No

If Yes, describe: ______________________________

Any current or history of being as sexual perpetrator? ____ Yes ___No

If Yes, describe: ______________________________

Cultural/Ethnic Issues

To which cultural or ethnic group, if any, do you belong? ______________________________

Are you experiencing any problems due to cultural or ethnic issues? ____ Yes ___No

If Yes, describe: ______________________________

Other cultural/ethnic information: ______________________________

____

Spiritual/Religious

How important to you are spiritual matters? __ Not ___ Little __Moderate _____Much

Are you affiliated with a spiritual or religious group? ____ Yes _____No

If Yes, describe: ______________________________

Were you raised within a spiritual or religious group? ____ Yes ____ No

If Yes, describe: ______________________________

Would you like your spiritual/religious beliefs incorporated into the counseling? ____ Yes __ No

If Yes, describe: ______________________________

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ____ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: ________________

____

Are you presently on probation or parole? ____ Yes _____No

If Yes, please describe: ____

Past History

Traffic violations: ____ Yes __ No DWI, DUI, etc.: ____ Yes __ No

Criminal involvement: ____ Yes __ No Civil involvement: ____ Yes __ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results

Education

Fill in all that apply: Years of education: ______ Currently enrolled in school? __ Yes___No

__ High school grad/GED _________List grade you stopped attending school in:___________

__ 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, AD/HD, gifted):_______________________________________

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Currently: ____ FT ___ PT ___ Temp __ Laid-off ___ Disabled ___ Retired

__ Social Security ____ Student ____ Other (describe): ____________________________

How many hours do you work a week? ______20 _______30 ________40 ________50 _______50+

Has anyone told you that they think that you work too much? ______Yes ______ No If yes, who told you that you work too much? ____

Are you a workaholic? _________Yes _______No If yes, why do you think so? _______________

____

Military

Military experience? ___ Yes __ No Combat experience? ____________ Yes ____ No

Where: ____

Branch: ______________________ Discharge date: ______________________

Date drafted: ______________________ Type of discharge: ______________________

Date enlisted: ______________________ Rank at discharge: ______________________

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?

Do you visit the internet? ______Yes ________ No If yes, how much time do you spend on the internet daily and during an average week? __________Daily time ________Weekly time Do you think that you may have an internet overuse problem?_____Yes ____No Has anyone told you that they think that you may have an internet use/abuse problem? _______Yes _______No If yes, do you believe them or not? ____Yes ____ No If yes, please explain:______________

Medical/Physical Health

Please check the symptoms that you are presently having or being treated for:

___ AIDS
___ Alcoholism
___ Abdominal pain
___ Abortion
___ Allergies
___ Anemia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bronchitis
___ Bed wetting
___ Cancer
___ Chest pain
___ Chronic pain
___ Colds/Coughs
___ Constipation
____ Dizziness
____ Drug abuse
____ Epilepsy
____ Ear infections
____ Eating problems
____ Fainting
____ Fatigue
____ Frequent urination
____ Headaches
____ Hearing problems
____ Hepatitis
____ High blood pressure
____ Kidney problems
____ Measles
____ Mononucleosis
____ Mumps
____ Nose bleeds
____ Pneumonia
____ Rheumatic Fever
____ Sexually transmitted disease
____ Sleeping disorders
____ Sore throat
____ Scarlet Fever
____ Sinusitis
____ Small Pox
____ Stroke
____ Sexual problems
____ Tonsillitis
____ Tuberculosis
____ Toothache
____ Thyroid problems
____ Vision problems

__ Chicken Pox	___ Menstrual pain	___ Vomiting
__ Dental problems	___ Miscarriages	___ Whooping cough
__ Diabetes	___ Neurological disorders	___ Other (describe): ________
__ Diarrhea	___ Nausea	____________

List any current health concerns: ____________________

List any recent health or physical changes: ____________________

____

What is the name of your primary care physician? ____________________

Nutrition

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____ / week	____________	___ No __ Low ___ Med ___ High
Lunch	____ / week	____________	___ No __ Low ___ Med ___ High
Dinner	____ / week	____________	___ No __ Low ___ Med ___ High
Snacks	____ / week	____________	___ No __ Low ___ Med ___ High

Comments: ____________________

____

What is the name of your nutritionist? ____________________

Current Medications Taken

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 Do you abuse prescription drugs?

_____ Yes _______ No What do you abuse?____________________

If Yes, describe: ____________________

____

Medical Information

	Date	Reason	Results
Last physical exam	______	______	______
Last doctor's visit	______	______	______
Last dental exam	______	______	______
Most recent surgery	______	______	______
Other surgery	______	______	______
Upcoming surgery	______	______	______

Family history of medical problems: ____

____

Pleases 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: ____________________

____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	______	______	______	______	___	___	___	___
Barbiturates	______	______	______	______	___	___	___	___
Valium/Librium	______	______	______	______	___	___	___	___
Cocaine/Crack	______	______	______	______	___	___	___	___
Heroin/Opiates	______	______	______	______	___	___	___	___
Marijuana	______	______	______	______	___	___	___	___
PCP/LSD/Mescaline	______	______	______	______	___	___	___	___
Inhalants	______	______	______	______	___	___	___	___
Caffeine	______	______	______	______	___	___	___	___
Nicotine	______	______	______	______	___	___	___	___
Over the counter	______	______	______	______	___	___	___	___
Prescription drugs	______	______	______	______	___	___	___	___
Other drugs	______	______	______	______	___	___	___	___

Substance(s) of preference

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Substance Abuse Questions

Describe when and where you typically use substances: ____

____

Describe any changes in your use patterns: ____

____

Describe how your use has affected your family or friends (include their perceptions of your use): ____

____

Reason(s) for use:

__ Addicted ____ Build confidence ____ Escape ____ Self-medication

__ Socialization ____ Taste ____ Other (specify): ____________________

How do you believe your substance use affects your life? ______________________________

Who or what has helped you in stopping or limiting your use? ___________________________

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):______________________

____

Does your body temperature change when you drink? ____ Yes __ No

If Yes, describe: ____

Have drugs or alcohol created a problem for your job? ____ Yes __ No

If Yes, describe: ____

Do you think you have an alcohol or drug use/abuse problem?_________Yes __________No If yes, please describe the problem:____

____

Counseling/Prior Treatment History

Information about client's treatment history (past and present):

	Yes	No	When	Where	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,	____	____	____________	____________________	______________

Information about family/significant others (past and present):

	Yes	No	When	Who	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
____ AD/HD
____ Withdrawing
____ Worrying
____ Other (specify): _________
____

Briefly discuss how the above symptoms impair your ability to function effectively: ________________

____

____

____

Do you have a history of physical, sexual, or emotional abuse? __________________________________

____

____

Do you have a history of domestic violence in your relationships? _______________________________

____

____

Do you feel suicidal or homicidal at this time? ____

No ____Yes ____

____

____

____

Have you felt suicidal or homicidal in the past week? No ____Yes

____

____

Signature Page

I have answered all of these questions to the best of my ability and I have been honest and truthful in the information that I have provided to Danielle C. Ellis.

Client's signature ____ Date: _____/____/______