

**GRACE COUNSELING CENTER
PERSONAL HISTORY INFORMATION**

Name: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____

(other) _____

Spouse/Partner: _____ Age: _____

Marital status:

Never married _____ Married _____ Divorced _____ Separated _____ Widowed _____

(How long? _____ _____ _____ _____)

FAMILY HISTORY:

Father

Mother

Names: _____

Ages: _____

Where do they live? _____

If deceased, dates: _____

Brothers and Sisters (oldest to youngest)

Name(s): Age: Sex: Occupation: Where living: Deceased?(Y/N)

Your Children's Names: Age: Sex: Grade: Lives at home? Step?

PERSONAL HISTORY:

Employment:

Current employer: _____

Length of employment: _____

Job title/duties: _____

Previous experience: _____

Military: Current _____ Previous _____ N/A _____

Branch: _____ Active duty? _____ Combat? _____

Discharge date: _____ Type of discharge: _____

Education:

Highest grade achieved: _____
Name of College/Vocational School: _____
Year of Graduation: _____ Degree: _____
Graduate or Professional School: _____

Legal: Current _____ Previous _____ N/A _____
Charges: _____ Probation? _____
Court district: _____

Abuse: Current _____ Previous _____ N/A _____
Type: Verbal/Emotional _____ Physical _____ Sexual _____
Who was/is the abuser(s)? _____
Have you ever abused anyone? _____

Substance abuse: Current _____ Previous _____ N/A _____
Past week? _____ Past month? _____ Past year? _____
Type(s): _____
Amount: _____ Frequency: _____
Has alcohol/drug use ever caused a problem? _____ If yes, explain: _____

Have you ever been treated for substance abuse? _____
Have you ever attended a 12-Step Group? _____ If yes, explain: _____

Does anyone in your family have alcohol/addiction problems? _____

Trauma:
List any significant past trauma experienced by you or those close to you (i.e., death, divorce, sickness, crime, etc.) _____

Social History:
How do you generally get along with people? _____
How many close friends do you have? _____
What do you like to do socially: _____
What leisure activities do you enjoy: _____

Religion:
Religious background: _____
Do you attend a church? _____
Name of church: _____
What part does God play in your life? _____

Medical History:

Physician: _____ City: _____

Date last seen: _____ Reason: _____

Ongoing medical conditions: _____ Allergies: _____

Medication(s): _____

Previous Mental Health Treatment:

Yes _____

No _____

Previous counselor(s): _____

How long ago: _____ Where: _____

Treatment for: _____ How many sessions: _____

Other family members in treatment: _____

Current Mental Health Treatment:

Are you seeing another counselor for any reason? _____

Do you have any current suicidal or homicidal thoughts? _____

DAILY ROUTINE:

Eating:

How is your appetite? _____

Any changes in the last six months? _____

Recent weight loss or gain? _____

Problems in eating habits? _____

Sleeping:

How well do you sleep? _____

Any changes in the last six months? _____

Fall asleep OK? _____ Stay asleep? _____

Feel rested during the day? _____

Energy level during the day? _____

Additional Comments:

Your Signature: _____ **Date:** _____

Thank you for your cooperation!