Freedom Counseling Center
Confidential Personal History Form

Client's Name: _____ Date of Birth: _____

If you need any more space for any of the questions, please use back of the sheet.

Primary reason(s) for seeking services:

☐Anger management	☐Anxiety	☐Depression	
☐Eating disorder	☐Fear/phobia	☐Grief	☐Sexual concerns
☐Sleeping problems	☐Addiction	☐Alcohol/drugs	☐Marriage
☐AD/HD	☐PTSD	☐Parenting Issues	☐Child Behavioral Problem

☐Other concerns (specify): _____

Family Information

Marital Status

☐Single	☐Married	
☐Divorced	☐Living with significant other	
☐Separated	☐Divorce in process	☐Widowed

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

Spouse/Partner's Name: _____

Children (names & ages): _____

_____

_____

Family of Origin

Raised by: _____

_____

Number of Siblings: _____ Your Birth Order: _____

Development

Are there special, unusual, or traumatic circumstances that affected your development?

☐Yes ☐ No If yes, please describe: _____

_____

Legal

Are you involved in any active cases (traffic/civil/criminal)? ☐Yes ☐No

If yes, please describe & indicate the charges: _____

_____

Are you presently on probation or parole? ☐Yes ☐No

If yes, please describe: _____

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Education

Fill in all that apply: 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

Current Employer Dates Title

_____

_____

Currently: ☐FT ☐PT ☐Temp ☐Laid-off ☐Disabled ☐Retired

☐Social Security ☐Student ☐Other (describe): _____

Military

Military experience? ☐Yes ☐No Combat experience? ☐Yes ☐No

Leisure/Recreational

Describe special areas of interest or hobbies (e.g. art, books, crafts, physical fitness, etc.)

_____

Medical/Physical Health

☐AIDS
☐Alcoholism
☐Abdominal Pain
☐Abortion
☐Allergies
☐Anemia
☐Appendicitis
☐Arthritis
☐Asthma
☐Bronchitis
☐Bed wetting
☐Cancer
☐Dizziness
☐Drug abuse
☐Epilepsy
☐Ear infections
☐Eating problems
☐Fainting
☐Fatigue
☐Frequent urination
☐Headaches
☐Hearing problems
☐Hepatitis
☐High blood pressure
☐Nose bleeds
☐Pneumonia
☐Rheumatic Fever
☐Sexually transmitted diseases
☐Sleeping disorders
☐Sore throat
☐Scarlet Fever
☐Sinusitis
☐Smallpox
☐Stroke
☐Sexual problems
☐Tonsillitis

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☐ Chest pain	☐ Kidney problems	☐ Tuberculosis
☐ Chronic pain	☐ Measles	☐ Toothache
☐ Colds/Coughs	☐ Mononucleosis	☐ Thyroid problems
☐ Constipation	☐ Mumps	☐ Vision problems
☐ Chicken pox	☐ Menstrual pain	☐ Vomiting
☐ Dental problems	☐ Miscarriages	☐ Whooping cough
☐ Diabetes	☐ Neurological disorders	☐ Diarrhea
☐ Nausea	☐ Other (describe): _____	

List any current health concerns: _____
List any recent health or physical changes: _____
_____
Primary Care Physician: _____
Psychiatrist: _____
Current prescribed medication: _____
_____
Current over-the-counter meds: _____

Please 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 which you checked above: _____
_____
_____

Chemical Use History

List any substances of current or historical abuse, including frequency & longevity of use:
_____
_____
_____

Substance of preference:
1. _____
2. _____
3. _____
4. _____

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Counseling/Prior Treatment History

Information about client (past & present):

	Yes	No	When	Where	Overall Reaction
Counseling					
Psychiatric Treatment					
Suicidal thoughts/attempts					
Drug/alcohol Treatment					
Hospitalizations					
Self-help groups (AA, Al-Anon)					

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

☐ Aggression	☐ Elevated mood	☐ Phobias/fear	☐ Alcohol dependence
☐ Fatigue	☐ Recurring thoughts	☐ Anger	☐ Cyber addiction
☐ Anxiety	☐ Hallucinations	☐ Sexual difficulties	☐ Sexual addiction
☐ Panic attacks	☐ Heart palpitations	☐ Sick often	☐ Avoiding people
☐ Chest pain	☐ Sleeping problems	☐ Hopelessness	☐ High blood pressure
☐ Gambling	☐ Speech problems	☐ Impulsivity	☐ Suicidal thoughts
☐ Depression	☐ Irritability	☐ Distractibility	☐ Thoughts disorganized
☐ Disorientation	☐ Judgment errors	☐ Trembling	☐ Memory impairment
☐ Loneliness	☐ Withdrawing	☐ Dizziness	☐ Eating disorder
☐ Worrying	☐ Drug dependence	☐ Mood shifts	☐ Antisocial behavior

☐ Other (specify): _____

Any additional information that would assist us in understanding your concerns/problems:

_____

_____

_____

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