

Personal History Form—Adult (18+)

The Family Resource Center

Please complete all items on this form and return to Dr. Garlock.

Our Fax Number Is 281-444-2678 And Email Is jagvw@earthlink.net

Thank You!

Client's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

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

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

Phone (home): _____ (work): _____ ext: _____

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 Dr. Garlock's services today?

What services do you want to receive from Dr. Garlock to address the issues listed above:

What made you decide to seek Dr. Garlock's services now and not at another time?

Who do you believe is important in the resolution of these concerns and should participate in the services?

What outcome are you hoping for or expecting by coming to see Dr. Garlock today?

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 Dr. Garlock is providing are successful?

Current Family Information

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___

Significant others (brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	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: _____

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:

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

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: Some days I have no appetite.

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: _____

Plases 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: _____

Tobacco And Caeffine Use History

Do you use tobacco? ___ Yes ___ No If yes, how much do you use daily? _____

How many cigarettes and cigars do you smoke a week? _____

How long have you been smoking? _____ Years _____ Months

What brand do you smoke? _____

Do you have any health problems related or due to smoking? ___ Yes ___ No

Are you being treated for illnesses related to your tobacco use? ___ Yes ___ No What are

You being treated for? _____

Have you tried to quit smoking? ___ Yes ___ No When did you try to quit smoking? _____

Do you use caeffine? ___ Yes ___ No If yes, what do you use? _____

How many soft drinks do you drink a day? _____

How many cups of coffee or tea do you drink daily? _____

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 | ___ Elevated mood | ___ Phobias/fears |
| ___ Alcohol dependence | ___ Fatigue | ___ Recurring thoughts |
| ___ Anger | ___ Gambling | ___ Sexual addiction |
| ___ Antisocial behavior | ___ Hallucinations | ___ Sexual difficulties |
| ___ Anxiety | ___ Heart palpitations | ___ Sick often |
| ___ Avoiding people | ___ High blood pressure | ___ Sleeping problems |
| ___ Chest pain | ___ Hopelessness | ___ Speech problems |
| ___ Cyber addiction | ___ Impulsivity | ___ Suicidal thoughts |
| ___ Depression | ___ Irritability | ___ Thoughts disorganized |
| ___ Disorientation | ___ Judgment errors | ___ AD/HD |
| ___ Distractibility | ___ Loneliness | ___ Withdrawing |
| ___ Dizziness | ___ Memory impairment | ___ Worrying |
| ___ Drug dependence | ___ Mood shifts | ___ Other (specify): _____ |
| ___ Eating disorder | ___ Panic attacks | _____ |

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

What meaning do your symptoms have for you in terms of your daily living and need meeting?

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

What are your goals for therapy? _____

How will you know if your goals for service delivery have been met?

Do you feel suicidal at this time? No Yes _____

Other Information That You Would Like Dr. Garlock To Know About You:

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 Dr. Garlock

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