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Personal Experience Information

Name: _____ Date: _____

Gender Identity and Preferred Pronouns: _____

This form is intended to help me understand you, your present concerns and your needs in our work together. If you have questions or if you are not clear about any of these items, please put a question mark (?) next to it and discuss it with me.

BACKGROUND AND CURRENT CONCERNS

Check any/all of the issues which pertain to you.

Job issues	Depression	Reproductive issues
Career decisions	Sleep/insomnia	Sexual problems
Relationship problems	Suicidal thoughts	Sexual orientation
Separation or divorce	Anxiety	Alcohol use
Parenting issues	Panic	Drug use
Domestic violence	Concentration	Co-dependency
Financial matters	Memory	ACOA
Legal matters	Shyness	Grief issues

Describe your current concerns.

_____

_____

_____

Do you face any immediate challenges that we should address as soon as possible? _____

If yes, please describe.

_____
_____
_____

Check any/all of the following that accurately describe your present or recent feelings.

Depressed or sad	Confused	Lonely	Anxious
Angry	Jealous	Guilty or Ashamed	Out of Control
Sick to my Stomach	Hopeless	Numb	Exhausted
Tearful	Desperate		

Who suggested you contact this office? _____

EDUCATION, EMPLOYMENT AND MILITARY HISTORY

Education:

	Name	Dates	Degree
High School			
College			
Graduate School			

Employment:

What is your current occupation and place of employment?

_____
_____
_____

Briefly Describe your Work History.

Place	Position	Dates

Military:

Have you served in the armed forces? _____
If yes, please indicate:
Branch and Rank: _____
Enlistment/Discharge Dates: _____
Rank: _____

MEDICAL, PSYCHOTHERAPY AND LEGAL HISTORY

Medical:

What medications or supplements are you now taking? Please specify the purpose of each.

Medication or Supplement Daily Dose Purpose

_____
_____
_____
_____
_____
_____

How would you describe your physical health?

Poor Average Good Excellent

Do you have any current physical illnesses that need to be addressed or which may complicate treatment? _____

If yes, please describe.

_____
_____
_____

What is the name of your physician? _____

When was your last visit with your physician? _____

Have you had any major health issues? _____

If yes, please describe.

_____
_____
_____

Abuse/Trauma:

Have you ever been sexually abused? _____

If yes, please describe when and by whom.

_____
_____
_____

Have you ever been emotionally and/or verbally abused? _____

If yes, please describe when and by whom.

_____
_____
_____

Have you experienced other significant life events (losses, deaths, hardships)? _____
If yes, please describe.

_____
_____
_____

Have you ever engaged in self-harm? _____
If yes, please describe.

_____
_____
_____

Is there any history of suicide in your family? _____
If yes, please describe.

_____
_____
_____

Have you ever attempted suicide?
If yes, please describe when and how.

_____
_____
_____

Psychotherapy:

Have you ever been in psychotherapy or seen a mental health professional? _____
If yes, please describe.

_____
_____
_____

What is the name of the therapist? _____
What were the approximate dates of your treatment?

_____
_____
_____

Alcohol and Drug History:

How often do you drink? _____
How much do you drink at those times? _____
How many times in the last year have you had five or more drinks in a single day? _____
Do you use or abuse drugs? _____
If yes, please describe.

_____
_____
_____

Have you ever driven a car after consuming alcohol or other mind/mood altering substance? _____
If yes, please describe.

_____
_____
_____

Have you ever been charged/arrested for a DUI? _____
If yes, please describe.

_____
_____
_____

Have you ever done anything while under the influence of alcohol or other drugs that you later regretted?
If yes, please describe.

_____
_____
_____

Have you ever received drug or alcohol treatment services before? _____
If yes, please describe.

Treatment Date From Whom For What Outcome

_____
_____
_____

Do family members have problems with drugs or alcohol? _____
If yes, please describe.

_____
_____
_____

Mental Health Hospitalizations:
Have you been hospitalized for a psychiatric condition? _____
If yes, please describe.
_____
_____
_____

Do family members have mental health problems? _____
If yes, please describe.
_____
_____
_____

Legal System History:
Have you been involved with the legal system (criminal or civil)? _____
If yes, please describe.
_____
_____
_____

Have you ever been in jail and/or prison?
If yes, please describe.
_____
_____
_____

EMOTIONAL LIFE

Sources of Strength:
Please check any/all of the following that you consider to be sources of strength for you.

My Sense of Humor	My Religious Faith	My Patience
My Family	My Intelligence	My Courage
My Tenacity	My Commitment to:	My Competitivity

Other:

Coping Strategies:
When you are challenged or distressed by events in your life, what do you do to cope or to comfort yourself?
_____
_____
_____

SPIRITUALITY

What is your current religion or spiritual orientation? _____
Is your spiritual orientation different from that of your family? _____
If yes, how is it different?

_____
_____
_____

RECREATION

Are you now involved in any form of regular physical exercise? _____
If yes, please describe.

_____
_____
_____

Do you pursue any hobbies? _____
If yes, please describe.

_____
_____
_____

Thank you.

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