Office of Bob Oberlander, L.M.H.C**.**

ADULT PERSONAL HISTORY QUESTIONNAIRE

This questionnaire is intended to help me review general information quickly so that our discussion can focus on the particular reasons that led you to scheduling this appointment. Feel free to leave blank any questions that do not apply or that you would rather not answer. This form will be held in confidence as part of your client record.

Your Name _____ Today's Date _____

Please summarize your reasons for seeking services:

_____

_____

_____

_____

Educational-Military history

What is the highest school degree earned? _____

Did you receive any Special Education? ____ Tutoring? _____Alternative Schooling? _____

Have you ever served in the military? _____ If yes, please answer the following:

Dates of Service: _____ Type of Discharge: _____ Combat Experience? _____

Vocational history

What is your current occupation? _____

How long have you been employed in your present position? _____

Since becoming an adult, how many different jobs have you held? _____

Have you had periods of unemployment lasting four months or longer? _____

Have you made career changes? _____Y _____N

If yes, what was/were your previous occupation(s)?_____

Are you satisfied with your current job? _____Y _____N

Have there been any major changes in your work situation in the past year? ____Y ____N

If yes, please describe:_____

Medical history

Please list all medications that you are currently taking, including dosages if you know them. Please list all "over-the-counter" medications, sleep aids, vitamin, and herbal supplements. Continue list on the back side of this page if you need more space.

MEDICATION	DOSAGE	PRESCRIBED BY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SUBSTANCE	FOR (Condition or problem)
_____	_____
_____	_____
_____	_____

Have you ever had major surgery? _____Y _____N

Have you ever had a head injury resulting in loss of consciousness, changes in thinking,

emotions or behavior? _____Y _____N

Have you ever had an extremely high fever (greater than 103 degrees F)? _____Y_____N

Have you ever fainted or had a seizure? _____Y _____N

Do you have any medication or food allergies or sensitivities? _____Y _____N

If yes, please specify:_____

Do you engage in regular physical exercise? _____Y _____N

Do you, or have you in the past, regularly used cigarettes or other tobacco products?
_____Y _____N

Please list any other medical conditions or concerns:_____

_____

Date of last medical examination: _____

Psychological treatment history

Have you ever taken medication for psychological/psychiatric reasons? _____Y_____N

If yes, please indicate when, and for what conditions/problems:_____

_____

Have you ever received counseling/therapy? _____Y _____N

If yes, when and by whom? _____

Have you ever been hospitalized for psychological/psychiatric reasons? _____Y _____N

Has anyone in your family (parents, grandparents, siblings, etc.) been diagnosed, and/or treated for psychological/psychiatric conditions? _____Y_____N

Alcohol/Drug history

If you drink alcohol, please describe the type of alcoholic beverage, the amount, and the frequency:_____

_____

If you have used, or currently use any street drugs, please describe which ones and your pattern of use: _____

_____

Have you ever tried to cut down on your use of alcohol or drugs? _____Y_____N

Has anyone gotten angry at you because of your alcohol or drug use? _____Y _____N

Have you ever felt guilty or worried about your use of alcohol or drugs? _____Y____N

Have you ever received outpatient alcohol and/or drug treatment or detoxification services?
_____Y _____N

Has anyone in your family had a problem with alcohol or drugs? _____Y _____N

Please describe your past and current use of over-the-counter medications, cigarettes and/or caffeine: _____

_____

Legal history

Please check all legal actions or proceedings you have been a part of:

_____Arrests/assault _____ Arrests/other* _____DUI (How many?_____)

_____Restraining/Protective order _____Child Protective Services _____Divorce/custody

_____Disability claim(s)

_____Other (describe)_____

Personal information

Have you experienced a loss (death, divorce, or significant situational loss) in the past two years? _____Y _____N

Did you experience any of the losses mentioned above during childhood or adolescence?
_____Y_____N

If yes, please describe:_____

Have you relocated in the last 2 years? _____Y _____N

How many siblings do you have, and what is your birth order among them? _____Y_____N

Were you adopted or separated from your birth parents during childhood? _____Y_____N

Were your parents divorced? _____Y _____N

If yes, how old were you at the time of their separation? _____

Please indicate your parents' current ages, or their ages at the time of their deaths.

_____

Has religion or spirituality played an important role in your life? _____Y _____N

Do you own or have access to firearms? _____Y _____N

Feel free to use the space below for any additional information or to describe your goals for counseling._____

_____

_____

_____

_____

_____

Your signature _____Date_____

Reviewed by _____Date _____