**Registration Form**
**Kimberly Esau, MA, LMFT**

## ADULT PERSONAL HISTORY FORM

Client's Name _____ Date _____

Gender ___F __M Date of Birth _____ Age _____

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

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ Work _____ext. _____

Cell _____ E-mail _____

Is it okay to leave a message? *(Please circle)* **At Home?** Y N **At work?** Y N **Cell?** Y N

**IF YOU NEED ANY MORE SPACE FOR ANY OF THE FOLLOWING QUESTIONS PLEASE USE THE BACK OF THE SHEET**

Primary reason(s) for seeking services:

__Anger management __Anxiety __Addictive behaviors __Alcohol/drugs
__Eating disorder __Fear/Phobias __Coping __Depression
__Sleeping problems __Relationship difficulties __Mental confusion __Sexual concerns
__Other mental health concerns (please describe)___
_____

## 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, Previous spouses. Please specify relationship.)

| Relationship | Name | Age | Living | | Living with you | |
|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Marital Status (more than one answer may apply)**

__Single

__Divorce in process
Length of time _____

__Unmarried, living together
Length of time _____

__Legally married
Length of time _____

__Separated
Length of time _____

__Divorced
Length of time _____

__Widowed
Length of time _____

__Annulment
Length of time _____

__Total number of marriages _____

Assessment of Current Relationship (if applicable) ___Good ___Fair ___Poor

**Parental Information**
__Parents legally married
__Parents have been separated
__Parents ever divorced

__Mother remarried: Number of times _____
__Father remarried: Number of times_____

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)
_____

_____

## DEVELOPMENT

Are there special, unusual, or traumatic circumstances that have affected your development: __ No __Yes

If Yes, which type(s) of child abuse? __Sexual __Physical __Verbal Abuse was as __Victim __Perpetrator

Other childhood issues: __Neglect __Inadequate nutrition __Other (specify) _____

Comments re: Childhood Development _____

_____

_____

## SOCIAL RELATIONSHIPS

Check how you generally get along with other people: (check all which apply)
__Affectionate __Aggressive __Avoidant __Fight/argue often __Follower
__Friendly __Leader __Outgoing __Shy/withdrawn __Submissive
__Other (specify) _____

Sexual Orientation: _____ Comments: _____

Sexual Dysfunction? __No __Yes (describe) _____

Any current or history of being a sexual perpetrator? __No __Yes (Describe) _____

## CULTURAL/ETHNIC

From which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? __No __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? __No __Yes (describe) _____

Were you raised within a spiritual or religious group? __No __ Yes (describe) _____
_____

Would you like your spiritual/religious beliefs incorporated into the counseling? __No __Yes (describe) _____
_____

## LEGAL

**Current Status**

Are you involved in any active cases (traffic, civil, criminal)? __No __Yes

If Yes, please describe and indicate the court and hearing/trial dates and charges _____
_____

Are you presently on probation or parole? __No __Yes

If Yes, please describe _____
_____

**Past History**

| | | | |
|---|---|---|---|
| Traffic violations | __No __Yes | DWI, DUI, etc. | __No __Yes |
| Criminal involvement | __No __Yes | Civil Involvement | __No __Yes |

If you responded Yes to any of the above, please fill in the following information.

| Charges | Date | Where (city) | Results |
|---|---|---|---|
| | | | |
| | | | |

## EDUCATIONAL

**Fill in all that apply**
__High School grad/GED

Years of education _____
__Vocational: Number of years _____
__College: Number of years _____
__Graduate: Number of years _____

Currently enrolled in school __No __Yes
Graduated __No __Yes Major _____
Graduated __No __Yes Major_____
Graduated __No __Yes Major_____

Other training: _____

Special circumstances (e.g. learning disabilities, gifted, etc.) _____

## EMPLOYMENT

Begin with most recent job, list job history:

| Employer | Dates | Title | Reason left job | How often miss work? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Currently: __FT __PT __Temp __Laid-off __Disabled __Retired __Social Security __Student

__Other (describe) _____

## MILITARY

Military experience? __No __Yes Combat experience? __No __Yes 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.)

_____ _____

_____ _____

_____ _____

## MEDICAL/PHYSICAL HEALTH

Check all that apply and describe:

__AIDS
__Alcoholism
__Abdominal pain
__Abortion
__Allergies
__Anemia
__Appendicitis
__Arthritis
__Asthma
__Bronchitis
__Bed wetting
__Cancer
__Chest pain
__Chronic pain
__Colds/cough
__Constipation
__Chicken Pox
__Dental Problems
__Diabetes
__Diarrhea
__Dizziness
__Drug abuse
__Epilepsy
__Ear infections
__Eating problems
__Fainting
__Fatigue
__Frequent urination
__Headaches
__Hearing problems
__Hepatitis
__High Blood Pressure
__Kidney Problems
__Measles
__Mononucleosis
__Mumps
__Menstrual pain
__Miscarriages
__Neurological disorders
__Nausea
__Nose bleeds
__Pneumonia
__Rheumatic Fever
__Sexually transmitted disease
__Sleeping disorders
__Sore throat
__Scarlet Fever
__Sinusitis
__Small Pox
__Stroke
__Sexual problems
__Tonsillitis
__Tuberculosis
__Toothache
__Thyroid problems
__Vision problems
__Vomiting
__Whooping cough
__Other (describe)

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 | Comments |
|---|---|---|---|---|
| Breakfast | /week | | __No __Low __Med __High | |
| Lunch | /week | | __No __Low __Med __High | |
| Dinner | /week | | __No __Low __Med __High | |
| Snacks | /week | | __No __Low __Med __High | |

| Current Prescribed Medications | Dose | Dates | Purpose | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Current Over-the-Counter Med's | Dose | Dates | Purpose | Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are you allergic to any medications or drugs? ___No ___Yes (describe) _____

| | 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_____

_____

_____

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 areas in which you checked above _____

_____

## 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 of preference**

1. _____ 3._____

2._____ 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 and friends (include their perception 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 your use? _____

Does (Has) someone in your family (present/past) have (had) a problem with drugs or alcohol? __No __Yes (describe)

_____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? __No __Yes (describe) _____

_____

Have you had any adverse reactions or overdose to drugs or alcohol? (describe) _____

_____

Does your body temperature change when you drink? __No __Yes (describe)_____

_____

Have drugs or alcohol created a problem for your job? __No __Yes (describe) _____

_____

## COUNSELING/PRIOR TREATMENT HISTORY

**Information about client (past and present):**

| | No | Yes | When | Purpose | Your reaction or 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) | | | | | |

**Information about family/significant others (past and present):**

| | No | Yes | When | Purpose | Your reaction or 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
__Alcohol dependence
__Anger
__Antisocial behavior
__Anxiety
__Avoiding people
__Chest pain
__Cyber addiction
__Depression
__Disorientation
__Distractibility
__Dizziness
__Drug dependence
__Eating disorder
__Elevated mood
__Fatigue
__Gambling
__Hallucinations
__Heart palpitations
__High blood pressure
__Hopelessness
__Impulsivity
__Irritability
__Judgment errors
__Loneliness
__Memory impairment
__Mood shifts
__Panic attacks
__Phobias/fears
__Recurring thoughts
__Sexual addiction
__Sexual difficulties
__Sick often
__Sleeping problems
__Speech problems
__Suicidal thoughts
__Thoughts disorganized
__Trembling
__Withdrawing
__Worrying
__Other (specify)
_____
_____
_____

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

_____

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

_____

What are your goals for therapy? _____

Do you feel suicidal at this time? __No __Yes (explain) _____

_____

**FOR STAFF USE**

_____ _____
Therapist's Signature/Credentials Date

Physician's Comments: _____

_____

_____ Physical exam: __Required __Not required

_____ _____
Physician's Signature and Credentials Date

Form adapted from *The Psychotherapy Documentation Primer (1999)*