



CATHOLIC CHARITIES
of St. Paul and Minneapolis

Counseling and Family Support Services
Personal History Form

Name: _____ Age: _____ D.O.B.: _____ Date: _____

Address: _____

Phone: _____ (home) _____ (work) _____ (cell/pager/voice mail)

Are the persons you live with
(family, partner, roommate, etc),
aware that you are seeking
counseling?
Yes / No

If needed, may we leave
voicemail messages for you?
Yes / No

Messages at work?
Yes / No

Who is / are your emergency contact person(s)?

Name: _____ Phone Number(s): _____

Medical

Do you have a primary care physician? _____
Name Location

Do you have a psychiatrist? _____
Name Location

Are you currently taking any medication? Yes / No
If Yes, are your taking medication as prescribed? Yes / No

Medication(s)

Name	Dosage	Condition	How Long	Improvement?
				Yes/No/Do not know
				Yes/No/Do not know
				Yes/No/Do not know
				Yes/No/Do not know
				Yes/No/Do not know
				Yes/No/Do not know
				Yes/No/Do not know
				Yes/No/Do not know

Client number: _____

Family History

FAMILY BACKGROUND									
	Name	Age	Year deceased	Quality of Relationship			Living with you?		
				Poor	OK	Close	Yes	No	
Father/Guardian							Yes	No	
Mother/Guardian							Yes	No	
Step-Parent							Yes	No	
Step-Parent							Yes	No	
Siblings							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
Grandparents									
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
Children									
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
							Yes	No	
Others									
							Yes	No	
							Yes	No	
							Yes	No	

Current and Past Marriages and Relationships with a Partner

Relationship	Name	Age	Length of Relationship	End Date	Year Deceased	Quality of Relationship Now			Status of Relation
						Poor	OK	Close	

Client number: _____

Does your family history include any of the following? (Please check all that apply)

Family Member	Alcoholism	Drug Use	Specify	Compulsive Gambler	Eating Disorder	Suicide/Attempt	Violent Behavior	Mental Health	Specify
Your Family									
Self									
Spouse/Partner									
Child									
Child									
Child									
Child									
Family of Origin									
Mother									
Father									
Brother/Sister									
Brother/Sister									
Brother/Sister									
Mother's Side									
Grandmother									
Grandfather									
Aunt/Uncle									
Father's Side									
Grandmother									
Grandfather									
Aunt/Uncle									
Others									
Former Spouse/ Partner									

Primary Residence Before Age 18?		
Residential History	Primary	Length of time
Two Parent		
Single Parent		
Extended Family		
Guardians		
Residential Schools		
Foster Parents		
Orphanage		
Psychiatric Institution		
Correctional Facility		

Therapist Comments (For Internal Use Only)
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Client number: _____

Does your family history include any of the following? (Please check all that apply)

Medical	Current	Past	Age of Onset	Family	N/A	Comments
Abortion						
ADD/ADHD						
Alzheimer's/Dementia						
Anemia						
Anorexia Nervosa						
Anxiety						
Arthritis						
Asthma						
Bipolar Disorder						
Bulimia Nervosa						
Cancer (external/internal)						
Chronic Fatigue						
Depression						
Diabetes I or II						
Emphysema/COPD						
Epilepsy						
Fibromyalgia						
Heart Disease						
Hepatitis C						
High Blood Pressure						
HIV/AIDS						
Kidney Disease						
Leukemia						
Liver Disease						
Lupus						
Major/Minor Surgery						
Miscarriage						
Osteoporosis						
Stroke						
Thyroid Disease						
Ulcer						
Other:						

Client number: _____

Concerns	Mild	Moderate	Severe	Past Problem	N/A	Comments
Relationship Stress						
Family Problems						
Work Stress						
Grief/Loss						
Sadness						
Sleep Disturbance						
Appetite Changes						
Feeling Hopeless						
Weakness/Fatigue						
Frequent Crying						
Low self-esteem						
Weight gain/loss						
Tension (neck/back)						
Excessive Worry						
Difficulty Breathing						
Dizziness/Headaches						
Hyperactivity/Impulsivity						
Hearing sounds/voices						
Intense/Frequent Anger						
Feeling out of control						
Sexual Problems						
Caffeine/Nicotine Use						
Alcohol/drugs abuse						
Restricted Eating						
Self-Induced Vomiting						
Laxative Use						
Physical Abuse						
Sexual Abuse						
Mood Swings						
Excessive Shopping						
Nightmares/Flashbacks						
Gambling						
Irritability						
Unusual Experiences						
Difficulty Concentrating						

Do you experience any of the following? (Please check all that apply)

Do you have any emergency health needs? Yes / No

Do you have any chronic medical problems that continue to interfere with your life? Yes / No

Client number: _____

Please Explain:

Have you experienced any of the following (within the past year)? (Please check yes / no)

<u>Yes / No</u> ___ ___ a death or birth of a loved one ___ ___ separation or divorce ___ ___ arrest or DWI ___ ___ change in living arrangements ___ ___ verbal/emotional abuse and/or harassment ___ ___ thoughts or acts of hurting yourself ___ ___ custody issues ___ ___ pregnancy ___ ___ disputes, arguments, physical fights w/ family members	<u>Yes / No</u> ___ ___ accident, fire or other disaster ___ ___ job loss or change ___ ___ major financial concerns ___ ___ physical abuse, assault, and/or threats ___ ___ thoughts or acts of violence towards others ___ ___ sexual assault, abuse, and/or sexual harassment ___ ___ unwanted, forced, or coerced sexual contact ___ ___ diagnosis of serious/terminal illness of you/family member ___ ___ legal proceedings
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List the three people who are the most supportive to you and their relationship to you:

Name: _____ / **Relationship:** _____

Name: _____ / **Relationship:** _____

Name: _____ / **Relationship:** _____

How often do you seek their support? _____

Do you currently participate in any spiritual/religious gatherings or groups? ___ Yes ___ No
What was the religious preference in the household that you were raised? _____
How important to you are spiritual/religious matters? Unimportant 1-----2-----3-----4-----5-----6-----7 Very Important
What is your present religious affiliation? American Indian ___ Buddhism ___ Christianity (Catholic, Orthodox, Protestant) ___ Hinduism ___ Islamic ___ Judaism ___ Specify (if not listed) _____
Would you like your spiritual/religious beliefs incorporated into your counseling? ___ Yes ___ No

What personal strengths have helped you handle stress? (Please Circle or Add Additional Below)

Sense of humor	Prayer	Thoughtfulness	Take charge ability	Perseverance	Creativity	Initiative	Connectedness to others
Others →							

What would you like to see change as a result of this counseling experience?

1. _____
2. _____
3. _____

How could you contribute to this change?

1. _____
2. _____
3. _____

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