

WINKE COUNSELING SERVICES PC
ADULT PERSONAL HISTORY

Clients Name: _____ Birthdate: _____

Reason for seeking treatment: _____

Goals you would like to achieve during treatment: _____

Family Information:

	Name	Sex	Age	Lives with you? Yes/No	Indicate if deceased
Spouse/ Significant other					
Children					
Mother					
Father					
Brothers / Sisters					

ISSUES THAT AFFECTED YOUR DEVELOPMENT (physical or sexual abuse, trauma -experienced or witnessed, nutrition, illness, neglect, etc.)

ADULT RELATIONSHIP HISTORY

Sexual Orientation: Heterosexual Lesbian Gay Bisexual Transgender

Your Current Marital Status: Single Married Separated Divorced Widowed Other

Your first marriage: _____ / _____ / _____
Age Date No. of Children If deceased, give date

Your second marriage: _____ / _____ / _____
Age Date No. of Children If deceased, give date

Check the best description of your relationship with your present significant other:

Excellent Good Fair Poor

SOCIAL INFORMATION

Social time is usually spent: Alone Immediate Family Peers

Please describe: _____

Do you isolate yourself from other people? _____

CULTURAL/ETHNIC BACKGROUND

What is the ethnic group(s) of your parents? _____

Do you identify with this same group, or another? _____

SPIRITUAL/RELIGIOUS BACKGROUND

Were you raised in a home that practiced a religion? Yes No

If yes, which religion: _____

Do you consider yourself a religious person? Yes No

Do you practice a formal religion now? Yes No

If yes, which religion? _____

Do you consider yourself a spiritual person? Yes No

LEGAL INFORMATION

Have you ever been involved with the police or courts? Yes No

If yes, please specify charge, date, result and if this was related to alcohol or other drug use:

Are you presently on parole or probation? Yes No

If yes, please explain: _____

MILITARY SERVICE

Have you ever served in the armed forces? Yes No

If yes, please include branch, enlistment date, discharge date, rank, and combat experience:

EDUCATION

Highest grade completed: _____ High School GED Some College College Degree:

_____ Graduate Degree: _____

Major

Field

LEISURE/RECREATIONAL

Hobbies, leisure time activities, interests: _____

Has your level of activity changed? Yes No If yes, explain how: _____

EMPLOYMENT/VOCATIONAL HISTORY

Employers (most recent 1 st)	Dates	Job Descriptions

Are you currently employed outside the home? Yes No Full time Part time

Special circumstances (underemployed, laid off, suspended, retired, etc): _____

Family Income: _____ Financial problems? Yes No If yes, explain: _____

COUNSELING/PRIOR TREATMENT HISTORY

Have you had psychotherapy/counseling or attended a support group before? Yes No If yes, please list below:

Name of Center	Type of Service Outpatient/inpatient/Day Treatment	Dates	Drug or Alcohol Treatment (Y/N)

Have you ever experienced thoughts of harming yourself or another person?
Yes No If yes, please explain: _____

Have you ever attempted to harm yourself or another person? Yes No
If yes, please explain: _____

Do you have a history of suicide attempts? Yes No If yes, please describe: _____

Family history of emotional problems? Yes No

Have you ever taken medications to treat mental health problems? Yes No
If yes, please list and indicate if they were effective or had any side effects.

Case Number: _____

CHEMICAL USE HISTORY

History of chemical use? Yes No If yes, please complete grid

Substance (circle or list)	Age at First use	Age at Regular use	Age at last use	Amount used In last 48 hrs.	Amount used in last 30 days
Alcohol Beer, wine, liquor					
Caffeine Coffee, energy drinks					
Nicotine Cigarettes, chewing tobacco, electronic cigarettes					
Cannabis Smoking, vaporizing, edibles, topical, tinctures					
Opiates/Prescription Pain Killers Heroin, Methadone, Suboxone, Oxycodone, Percocet, Vicodin					
Anti-anxiety Medications Xanax, Ativan, Klonopin, Valium, Ambien, other					
Amphetamines Methamphetamine, Ritalin, Adderall, diet pills,					
Cocaine Powder, crack					
Other Ecstasy, Molly, Spice, Cough Syrup, inhaled toxicants, LSD, Salvia, etc.					

Substance of Preference:

1. _____ 2. _____

Describe any changes in your use patterns: _____

Family members with a past or present problem with drugs or alcohol? _____

Do you have an increased tolerance to drugs or alcohol? Describe: _____

Have you had withdrawals when you tried to stop using? Yes No

If yes, describe: _____

Does your temperament change when you drink? (Describe) _____

Have you ever experienced blackouts? Yes No Ever overdosed? Yes No

Describe: _____

Has your use negatively affected your life (job, relationship, legal)? Yes No

Describe: _____

Other addictive behaviors? Gambling Spending Sex Other

Comment: _____

PHYSICAL HEALTH

Last date seen by physician and reason for seeing: _____

Medical Conditions (past & present, include surgeries, hospitalizations, and treatment procedures): _____

Case Number: _____

Any history of head injuries, concussions, or traumatic brain injuries?

Current medications & dosages (include over the counter medications and supplements):

Are you allergic to or have had a bad reaction to any medications? Yes No If yes, please list: _____

If you are female, are you pregnant? Yes No If you are, or become pregnant, during treatment, it is important to inform your doctor if taking any medication.

Client Signature: _____ Date: _____

STAFF USE ONLY

Therapist Signature _____ Date _____

Based on the information provided above, a physical exam Is Required Is Not Required

M.D./D.O. Comments _____

Physician Signature _____ Date _____

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