Leadem Counseling & Consulting Services, PC
668 Commons Way
Toms River, NJ 08755
732-797-1444

Personal History

Patient's name: _____ Date: _____

Gender: ___ F ___ M Date of birth: _____ Age: _____

Form completed by (if someone other than patient): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (home): _____(work): _____(cell) _____

If you need any more space for any of the questions please use the back of the sheet.

Primary reason(s) for seeking services:

☐ Anger management ☐ Anxiety ☐ Coping ☐ Depression
☐ Eating disorder ☐ Fear/phobias ☐ Mental confusion ☐ Sexual concerns
☐ Sleeping problems ☐ Alcohol/drugs ☐ Addictive behaviors
☐ Other mental health concerns (specify): _____

Family History

			Living		Living with you	
Relationship	**Name**	**Age**	**Yes**	**No**	**Yes**	**No**
Mother						
Father						
Spouse						
Children						

Significant others (e.g., brothers, sisters, grandparents, step-relatives, half-relatives. Please specify relationship.)

			Living		Living with you	
Relationship	Name	Age	Yes	No	Yes	No

Identify the relationships you can get the most support from & why?

_____

_____

Identify the relationships that you have the most difficulty with & why?

_____

_____

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Parental Information

☐ Parents legally married ☐ Mother remarried: Number of times:
☐ Parents have ever been separated ☐ Father remarried: Number of times:
☐ Parents ever divorced

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

Marital Status (more than one answer may apply)

☐Single ☐Divorce in process ☐ Unmarried, living together (Length of time) _____
☐ Legally married (Length of time) _____ ☐ Separated (Length of time) _____
☐Divorced (Length of time) _____ Total number of marriages: _____
☐ Widowed (Length of time) _____ ☐ Annulment (Length of time) _____
Assessment of current relationship (if applicable): ☐ Good ☐Fair ☐ Poor

Developmental

Do you experience any developmental delays? ☐ Yes ☐ No If yes describe:
_____

Are there special, unusual, or traumatic circumstances that affected your development? ☐ Yes ☐ No
If Yes, please describe: _____
Has there been history of child abuse? ☐ Yes ☐ No
If Yes, which type(s)? ☐ Sexual ☐ Physical ☐Verbal
If Yes, the abuse was as a: ☐Victim ☐ Perpetrator
Other childhood issues: ☐ Neglect ☐ Inadequate nutrition ☐ Other (please specify):
_____
Comments re: childhood development: _____
_____

Social Relationships

Check how you generally get along with other people: (check all that apply)
☐Affectionate ☐ Aggressive ☐ Avoidant ☐ Fight/argue often ☐ Follower
☐ Friendly ☐ Leader ☐ Outgoing ☐Shy/withdrawn ☐ Submissive
☐ Other (specify): _____
Sexual orientation: _____
Sexual dysfunctions? ☐ Yes ☐ No
If Yes, describe: _____
Any current or history of being a sexual perpetrator? ☐ Yes ☐ No
If Yes, describe: _____

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Cultural/Ethnic

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

Are you experiencing any problems due to cultural or ethnic issues? ☐ Yes ☐ No

If Yes, describe: _____

Other cultural/ethnic information or needs? _____

Spiritual/Religious

How important to you are spiritual matters? ☐ Not ☐ Little ☐ Moderate ☐ Much

Are you affiliated with a spiritual or religious group? ☐ Yes ☐ No

If Yes, describe: _____

Were you raised within a spiritual or religious group? ☐ Yes ☐ No

If Yes, describe: _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ☐ Yes ☐ No

If Yes, describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ☐ Yes ☐ No

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

_____

Are you presently on probation or parole? ☐ Yes ☐ No

If Yes, please describe: _____

Past History

Traffic violations: ☐ Yes ☐ No DWI, DUI, etc.: ☐ Yes ☐ No

Criminal involvement: ☐ Yes ☐ No Civil involvement: ☐ Yes ☐ No

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

Charges	Dates	Results

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Education

Fill in all that apply: Years of education:_____Currently enrolled in school? ☐Yes ☐ No

___ High school grad/GED

___ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

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

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left the job	How often miss work?

Current Job: ☐ FT ☐ PT ☐Temp ☐ Laid-off ☐Disabled ☐Retired ☐Social Security ☐Student

☐Other (describe): _____

Military

Military experience? ☐ Yes ☐ No Combat experience? ☐ Yes ☐ No

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.)

Activity	How often now?	How often in the past?

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Chemical Use History

	Method of use & amount	Frequency of use	Age first use	Age last use	Used in last 48 hours	Used in last 30 days
Alcohol by Type						
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 or friends (include their perceptions of your use): __

_____

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Chemical Use History con't

Reason(s) for use:

☐Addicted ☐Build confidence ☐ Escape ☐ Self-medication ☐ Socialization ☐ Taste

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

☐ Yes ☐ No If Yes, describe: _____

Have you had withdrawal symptoms when trying to stop using drugs or alcohol? ☐Yes ☐ No

If yes, describe: _____

Have you had adverse reactions or overdose to drugs or alcohol? (Describe):_____

_____

Have drugs or alcohol created a problem for your job? _____ Yes _____ No

If yes, describe: _____

Medical/Physical Health

☐ Aids	☐ Alcoholism	☐ Abdominal pain	☐ Abortion
☐ Allergies	☐ Anemia	☐ Arthritis	☐ Asthma
☐ Bed wetting	☐ Cancer	☐ Chest pain	☐ Chronic pain
☐ Dental Problems	☐ Diabetes	☐ Dizziness	☐ Drug abuse
☐ Epilepsy	☐ Eating problems	☐ Fainting	☐ Fatigue
☐ Headaches	☐ Hearing problems	☐ Hepatitis	☐ High BP
☐ Kidney problems	☐Menstrual pain	☐ Miscarriages	☐ Neurological problems
☐ Nausea	☐ Nose bleeds	☐ Rheumatic fever	☐ Sleeping problems
☐ Stroke	☐ Tuberculosis	☐ Tooth ache	☐ Thyroid problems
☐ Vision problems	☐ Sexually transmitted disease		

List any current health concerns: _____

List any recent health or physical changes: _____

_____

Current prescribed medications	Dose	Dates	Purpose	Side effects

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Medical/Physical Health Con't

Current over-the-counter meds	Dose	Dates	Purpose	Side effects

Are you allergic to any medications or drugs? ☐ Yes ☐ No

If 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: _____

Counseling/Prior Treatment History

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

	Yes	No	When	Where/How	Outcome
Counseling/Psychiatric					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Self-Help Group by Type					
Danger to Others					

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

	Yes	No	When	Where/How	Outcome
Counseling/Psychiatric					
Suicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Self-Help Group by Type					
Danger to Others					

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression
___ Alcohol use
___ Anger
___ Antisocial behavior
___ Anxiety
___ Avoiding people
___ Chest pain
___ Cyber addiction
___ Depression
___ Disorientation
___ Distractibility
___ Dizziness
___ Drug use
___ 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? ☐Yes ☐ No Do you want to hurt anyone at this time? ☐Yes ☐No

If Yes, explain: _____

Therapist's signature/credentials: _____ Date: _____/_____/_____