METROPOLITAN
PSYCHOLOGICAL ASSOCIATES, P.C.

Adult Personal History Form

Client Name: _____ Birth date:_____

Reason for seeking treatment:_____

_____

_____

Emergency contact:_____

Name *Phone*

	Name	Sex	Age	Lives with you	Indicate if Deceased
Spouse/Significant Other					
Children					
Mother					
Father					
Brothers/Sisters					

Parental Information

Children not listed or not living with you: _____

_____

Special Circumstances: _____

_____

Issues/Concerns that influenced your development (physical or sexual abuse, illness, neglect, etc.)

_____

_____

Adult Marital History

Your Current Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed □ Other

Your first marriage _____

Age Date No. of Children If Divorced Give Date

Your second marriage _____

Age Date No. of Children If Divorced Give Date

How would you describe your current relationship with you significant other:

□ Excellent □ Good □ Fair □ Poor

Social Information

Social time is usually spent: □ Alone □ Immediate Family □ Friends

Please describe: _____

_____

Do you isolate yourself from other people? _____

Cultural/Ethnic Background

What is the ethnic group of your parents? (Hispanic, African American, Asian, etc.)

_____

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 the courts? □ Yes □ No

If yes, please indicate

Charge Date Outcome Substance related

_____

_____

_____

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

If yes, please explain: _____

_____

Military Service

Have you ever been in the armed forces? □ Yes □ No

If yes, with who, where, and when? _____

Education

□ Did not complete high school □ High School Diploma □ GED □ Attend Night School

□ Some College □ College Degree _____ □ Graduate Degree _____

Major *Field*

List any vocational Training _____

Are you satisfied with your education □ Yes □ No If not, why? _____

Leisure/Recreational

List your hobbies. Leisure time activities, interests:_____

_____

Has your level of activity changed? □ Yes □ No If yes, please explain _____

_____

Employment/Vocational History

Employer	Dates	Job Description

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

Special Circumstances (laid-off, medical leave, suspended, etc.): _____

_____

Total Family Income: _____ Do you currently have financial problems? □ Yes □ No

If yes, please explain: _____

Mental Health Treatment

Have you had therapy/counseling before? □ Yes □ No If yes, please specify

Name of Center	Type of Service (Outpatient, Inpatient, etc.)	Reason for Treatment	Dates

Do you attend any support groups? □ Yes □ No If yes, describe: _____

Have you ever experienced thoughts of harming yourself or another person? □ Yes □ No

If yes, please describe _____

Have you ever attempted to harm yourself or another person? □ Yes □ No

If yes, please describe _____

Do you have a history of suicide attempts? □ Yes □ No

Is there any family history of mental health problems? □ Yes □ No If yes, please explain:

_____

_____

Please indicate if you are currently having any of the following difficulties, or have in the past:

	I have this now	**I had it in the past**
Difficulty falling asleep or staying asleep		
Sleeping too much		
Change in appetite, weight loss, or weight gain		
Frequent crying		
Thoughts of killing or hurting myself		
Attempts to kill or hurt myself		
Problems concentrating		
Periods of daily sadness that have lasted more than two weeks		
Little or no interest in sex		
Tired almost every day		
Problems remembering things		
Periods of time in which I felt so good or so hyper that other people thought I was not my usual self *or* I was so hyper that I got into trouble		
Startle easily		
Can't stop remembering upsetting past events		
Difficulty controlling my temper		
Physically hurt other people		
Break things sometimes		
Worry a lot		
Panic attacks or anxiety attacks		
Feeling that I or my surroundings are unreal		
Made myself throw up in order to lose weight		
Used laxatives or exercised excessively to lose weight		
Often feel like I am an outsider		
Sexual problems		
Worry that something is wrong with my body		
Frequent arguments with the people I live with		
Other (please list):		

Use of Substances

Please indicate the type and amount of substances you use: _____

_____

Please indicate any course of treatment undertaken for use of substances: _____

_____

Does, or has any member of your family suffered from any type of substance abuse problem?

□ Yes □ No If yes, please describe _____

Physical Health

Who is your current physician? _____

When was your last physical? _____ What were the reasons for your visit? _____

_____

Are you taking any medications? □ Yes □ No If yes, please list _____

_____

List any surgeries, hospitalizations, or past treatment procedures: _____

_____

Family history of medical problems: _____

_____

Client Signature_____ Date:_____

Clinician Signature_____ Date: _____