Adult Personal History

This form is to be completed only by clients in Family Support Services and Outpatient Counseling. Please, take your time and complete this entire form. The information you give us will help us understand you better and identify all the services that may be helpful to you.

Current Date: _____
Client Name: _____ Date of Birth: _____
Address: _____
Telephone Number(s): Home: (____) _____ Cell: (____) _____ Work: (____) _____

May we contact you and leave a message at: House Number: ☐ Yes ☐ No Cell: ☐ Yes ☐ No Work: ☐ Yes ☐ No
May we text you on your cell phone? ☐ Yes ☐ No
In order of preference, with 1 being most preferred, please indicate which number you prefer we call you:
Home:_____ Cell:_____ Work:_____
Email Address: _____ Is it ok for us to contact you at this email: ☐ Yes ☐ No

Emergency Contacts:
Contact #1: Name: _____ Telephone Number: (____) _____
Relationship: _____
Contact #2: Name: _____ Telephone Number: (____) _____
Relationship: _____

What recently happened to make you decide to seek help now? _____
_____
How would you like your life to be when you don't need any services from JFS? _____
_____
_____

Please check the items that affect you:

☐ Depression	☐ Feeling controlled	☐ Endangering others	☐ Decreased activity
☐ Crying spells	☐ Feeling talked about	☐ Gambling	☐ Decreased self-care
☐ Hopelessness	☐ Seeing things others don't	☐ Excessive spending	☐ Guilt/shame
☐ Relationship problems	☐ Unusual thoughts	☐ Anger	☐ Financial worries
☐ Relationship breakup	☐ Increased alcohol use or drug use	☐ Sexual behavior	☐ Sexual problems
☐ Loneliness	☐ Blackouts/memory loss	☐ Can't concentrate	☐ Anxiety
☐ Emptiness	☐ Withdrawal symptoms	☐ Confusion	☐ Clutter
☐ Loss of appetite	☐ Food bingeing	☐ Mood swings	☐ Constant Fears/Worries
☐ Sleep disturbance	☐ Purging	☐ Racing thoughts	☐ Gender Concerns
☐ Nightmares	☐ Yelling or breaking things	☐ Fear of dying	☐ Gender Orientation Concerns
☐ Hearing voices	☐ Endangering self	☐ Job stress	

Other: _____
_____

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Self-Harm Assessment and History

Do you have any thoughts now or recently of wishing you were dead? ☐ Yes ☐ No
Have you ever attempted suicide or tried to harm yourself? ☐ Yes ☐ No
If yes, when: _____
Please explain circumstances (how, why?):
Has anyone in your family attempted or died by suicide? ☐ Yes ☐ No
If yes, who? _____
Please explain: _____
Have you ever attempted to kill or seriously harm someone else? ☐ Yes ☐ No If yes, who? _____
Please explain: _____
Have you ever been the victim of physical, sexual or verbal abuse? ☐ Yes ☐ No
Do you currently, or have you in the past, participated in risk-taking behaviors? ☐ Yes ☐ No
Please explain: _____
_____

Trauma History

Have you ever experienced trauma: ☐ Yes ☐ No

Please check all of the items which you have experienced:

☐ Flood	☐ Death of close friends/family	☐ Family History of Mental Health Issues
☐ Fire	☐ Dysfunctional Family Dynamics	☐ Domestic Violence
☐ Serious Accident	☐ Combat	☐ Family History of Substance and/or alcohol use
☐ Assault	☐ Serious Medical Issues	

☐ Other: _____

Treatment History

Have you seen a therapist or counselor for personal, family problems, or alcohol/drug treatment? ☐ Yes ☐ No
If yes, when? _____ Where? _____
Reason: _____
_____
Any involvement in self-help support groups such as AA, NA, ACOA, CODA, RR, EE, AIM, etc.? _____
_____
Have you been in the hospital or residential treatment for personal problems or alcohol/drug problems? ☐ Yes ☐ No
If yes, when? _____ Where? _____
Reason: _____
_____
Were any of your treatment experiences helpful? ☐ Yes ☐ No
Please explain: _____
Have any family members been hospitalized for personal or alcohol/drug problems? _____
_____

Describe any cultural factors which might affect services i.e. religious observance, ethnicity, socioeconomic factors, immigration factors, etc.: _____
_____
Describe any special accommodations which are needed i.e. language, visual or hearing impairments, etc.: _____
_____

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Family History

Father: ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Mother: ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Stepfather, if applicable: ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Stepmother, if applicable: ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____

Who were you raised by? _____
Were you adopted? ☐ Yes ☐ No
Relationship to parents during childhood? ☐ Good ☐ Fair ☐ Poor
Were your parents divorced? ☐ Yes ☐ No Your age at time of divorce: _____ years

Sibling: ☐ Brother ☐ Sister ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Sibling: ☐ Brother ☐ Sister ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Sibling: ☐ Brother ☐ Sister ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Sibling: ☐ Brother ☐ Sister ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____
Sibling: ☐ Brother ☐ Sister ☐ Living ☐ Deceased ☐ Resides with you Age: _____ If deceased, age at death: _____

Current Relationship or Partnership Status

☐ Married/committed ☐ Never married/committed ☐ Living together ☐ Separated ☐ Divorced ☐ Widowed
Spouse/partner name & age: _____
Assessment of current relationship: ☐ Good ☐ Fair ☐ Poor
Age first married/in committed relationship? _____ Number of times married or lived with a partner? _____
Number of times divorced: _____
Who else lives with you other than those listed above? _____
Children: Names & Ages (please list below):

Name	Age	Name	Age

Social and Vocational History

Education

Last grade completed: _____ Degree: _____ In school now? ☐ Yes ☐ No
Special training or skills: _____
Educational plans: _____
Do you have any learning disabilities? ☐ Yes ☐ No If yes, explain:_____

Employment

Employed: ☐ Yes ☐ No Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No
Current Employer: _____ Title: _____ Years on job: _____

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Employment History: List from most recent
Employer: _____ Title: _____ Job: _____ Dates: _____
Employer: _____ Title: _____ Job: _____ Dates: _____
Employer: _____ Title: _____ Job: _____ Dates: _____
Employer: _____ Title: _____ Job: _____ Dates: _____
Have you ever been fired from a job? ☐ Yes ☐ No If yes, explain: _____
Do you have any problems on your current job? _____
Do you have any financial problems? ☐ Yes ☐ No If yes, explain: _____

Military
Have you ever served in the military? ☐ Yes ☐ No Branch: _____ Dates served: _____
If yes, type of discharge: _____
Did you have any combat experience? ☐ Yes ☐ No
Are you troubled by your military experience? ☐ Yes ☐ No If yes, explain: _____

Legal
Were you ever arrested? ☐ Yes ☐ No
If yes, indicate the date, the charge, if you were convicted and what was the sentence: _____
_____
Have you ever been convicted of a felony? ☐ Yes ☐ No Misdemeanor? ☐ Yes ☐ No
Are you currently on probation or parole? ☐ Yes ☐ No End date: _____
Do you have any upcoming court dates? ☐ Yes ☐ No If yes, when? _____
Have you ever filed for bankruptcy? ☐ Yes ☐ No If yes, date filed: _____ Date discharged: _____
Have you ever been evicted? ☐ Yes ☐ No If yes, date(s): _____ Reason: _____
Have you been involved with foreclosure proceedings? ☐ Yes ☐ No ☐ Pending

Current Interests and Activities

Please check all that apply:

☐ Television	☐ Go to school	☐ Read	☐ Write	☐ Exercise
☐ Movies/videos	☐ Art	☐ Gamble	☐ Watch sports	☐ Sing
☐ Video games	☐ Religious activities	☐ Listen to music	☐ Outdoor activities	☐ Play sports
☐ Play instrument	☐ Crafts	☐ Travel/sight see	☐ Other: _____	

☐ Affiliation with Synagogue/house of worship: _____

How do you relate to other people? ☐ Outgoing ☐ Introverted ☐ Keep to myself
Who do you socialize with? ☐ Family ☐ Friends ☐ Co-workers
Have you recently lost interest in activities that you normally enjoyed? ☐ Yes ☐ No
Do you feel you spend enough time on your interests, hobbies (non-work activities)? ☐ Yes ☐ No
Do you have any ethnic, cultural or religious concerns? ☐ Yes ☐ No
If yes, please explain: _____
Religious/cultural identification: _____
Are you a Holocaust Survivor: ☐ Yes ☐ No
Current religious/spiritual involvement/activities: _____
Describe any sexual, gender, or sexual orientation issues/concerns you have: _____
_____

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Physical Health History

Check all of the items that apply to you now or in the past:

☐ Allergies	☐ Hypoglycemia	☐ Cancer	☐ Asthma
☐ Diabetes	☐ Major Surgery	☐ Ulcers	☐ Low blood pressure
☐ Major accidents	☐ Head injury	☐ Hypertension (high blood pressure)	☐ Seizure
☐ Stomach problems	☐ Heart disease	☐ Migraine headaches	☐ Pancreatitis
☐ Bacterial endocarditis	☐ Chronic pain	☐ Liver disease	☐ Prolapsed mitral valve
☐ Injury from abuse	☐ Hepatitis	☐ Circulation problems	☐ Large weight gain
☐ Broken bones	☐ Thyroid problems	☐ High cholesterol	☐ Chronic fatigue
☐ Large weight loss	☐ Insomnia	☐ Appetite disturbance	☐ Impotence
☐ Irritable bowel	☐ Vision problems	☐ Sexually transmitted diseases	☐ Lupus
☐ Speech problems	☐ HIV Positive	☐ Back problems	☐ Hearing problems
☐ AIDS	☐ Eating disorders	☐ Developmental/Neurological Concerns	

If you checked any of the above, please provide additional information i.e. dates, reasons, results of evaluations, etc.:

_____

_____

_____

_____

_____

Significant family mental health history? ☐ Yes ☐ No

If yes, please explain: _____

Have you felt the need to cut down on your alcohol or drug use? ☐ Yes ☐ No

Do other people in your life complain about your alcohol or drug use? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol or drug use? ☐ Yes ☐ No

Do you ever have a drink or do drugs first thing in the morning to steady your nerves? ☐ Yes ☐ No

Comments/Other: _____

List all medications that you take:

_____

Are you allergic to any medication(s)? ☐ Yes ☐ No

If yes, name: _____

Primary healthcare physician's name: _____ Phone: _____

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

When was your last appointment with your physician? _____

Preferred hospital name (in case of an emergency): _____

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

Do you have health insurance? ☐ Yes ☐ No

If no, would you like to talk with a Health Insurance Enrollment Specialist? ☐ Yes ☐ No

If yes, what carrier: _____

Advanced Directives:

Do you have an advanced directive established? ☐ Yes ☐ No

If yes, what type? ☐ Living Will ☐ Power of Attorney ☐ Other: _____

Client signature: _____ **Date:** _____

Jewish Family Service Staff Signature: _____ **Date:** _____

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