FSS Adult Personal History

This form is to be completed only by clients in Family Support Services. 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: ____________________
Legal Name: ____________________ Also Known As: ____________________
Date of Birth: ____________________ Gender: ____________________
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
Citizenship: ____________________ Race/Ethnicity: ____________________
Country of Birth: ____________________ Religion (if any): ____________________
Veteran or Spouse of Veteran: ____________________
Marital Status: ☐ Single ☐ Married ☐ Living Together ☐ Separated ☐ Divorced ☐ Widowed ☐ Other: __________
Primary Language: ____________________ Secondary Language: ____________________
Please describe any special accommodations which are needed i.e. language, visual or hearing impairments, etc.:
____
____

Do you have a guardian/conservator/power of attorney/payee? ☐ Yes ☐ No
If yes, please explain: ____________________

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?

☐ Abuse or Neglect	☐ Excessive Spending	☐ Job Stress	☐ Safety Concerns
☐ Anxiety	☐ Financial Stress	☐ Lack of Support	☐ Significant Life Change
☐ Constant Fear/Worries	☐ Food Insecurity	☐ Legal Needs	☐ Transportation Needs
☐ Depression	☐ Foreclosure	☐ Loneliness	☐ Unaffordable Housing
☐ Difficulty Concentrating	☐ Gambling	☐ Mental Health	☐ Unemployment
☐ Divorce	☐ Grief/Loss	☐ Physical Health	☐ Utility Bills
☐ Eviction	☐ Lack of Health Insurance	☐ Relationship Problems	☐ Other: __________

Please explain: ____________________
____

How would you like your life to be when you don't need any services from JFS? ____________________
____
____

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Jewish Family Service OF METRO DETROIT

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Household Information

Household Size: ________________

Please list all individuals who currently live in your home:

Name:	Relationship: (example: spouse/ partner/daughter/son/roommate)	Date of Birth:
	self	

Additional explanation, if needed: ____

____

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 If yes, how many hours do you work per week? ____________________________

Retired: ☐ Yes ☐ No Unable to Work: ☐ Yes ☐ No If yes, explain: ____________________________

Current Employer: ____________________________ Title: ____________________ Years on job: __________

Employment History: (List from most recent)

Employer: _____________________ Title: ____________ Job: _________________ Dates: ______________

Employer: _____________________ Title: ____________ Job: _________________ Dates: ______________

Employer: _____________________ Title: ____________ Job: _________________ Dates: ______________

Employer: _____________________ Title: ____________ Job: _________________ Dates: ______________

Are you satisfied with your current job? ____

Do you have any problems at your current job? ____

Have you ever been fired from a job? ☐ Yes ☐ No If yes, explain: ______________________________

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Insurance

Do you have health insurance? ☐ Yes ☐ No If yes, what carrier: ____________________

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

Primary Care Physician (PCP)'s name: ____________________ Phone: ____________

Address: ____________________ City: ____________ State: _____ Zip: ________

Preferred hospital (in case of an emergency): ____________________

Address: ____________________ City: ____________ State: _____ Zip: ________

Legal

Your legal information can help us better understand your needs and identify all appropriate resources and supports:

Do you have any current legal needs: ☐ Yes ☐ No

If yes, please explain: ____________________

Have you ever been 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 Have you ever been convicted of a misdemeanor? ☐ Yes ☐ No

Are you currently on probation or parole? ☐ Yes ☐ No End date: ____________________

If yes, please provide the terms of your probation/parole: ____________________

Do you have any upcoming court dates? ☐ Yes ☐ No If yes, when? ____________________

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

☐ Bankruptcy ☐ Custody ☐ Divorce ☐ Eviction ☐ Foreclosure ☐ Adult or Child Protective Services (APS/CPS)

Please provide details for anything checked above: ____________________

____

Advanced Directives

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

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

<u>Health Information</u>

Please list current or previous physical health issues you have experienced: ____________________

____

Significant family physical health history? ☐ Yes ☐ No

If yes, please explain: ____________________

____

Please list current or previous mental health or substance abuse issues you have experienced: ____________________

____

Do you currently, or have you in the past, utilized mental health or substance abuse treatment? ☐ Yes ☐ No

If yes, please explain: ____________________

____

Significant family mental health history? ☐ Yes ☐ No

If yes, please explain: ____________________

____

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Self-Harm Assessment

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

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: ___

Do you currently, or have you in the past, participated in risk-taking behaviors? ☐ Yes ☐ No

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: ___

Trauma History

Have you ever experienced trauma? ☐ Yes ☐ No

Please check all of the items which you have experienced:

- ☐ Flood
- ☐ Fire
- ☐ Serious Accident
- ☐ Assault
- ☐ Death of Close Friends/Family
- ☐ Dysfunctional Family Dynamics
- ☐ Combat
- ☐ Serious Medical Issues
- ☐ Family History of Mental Health Issues
- ☐ Domestic Violence
- ☐ Family History of Alcohol/Substance Use
- ☐ Other: ___

Are you currently in a controlling or abusive relationship? ☐ Yes ☐ No

Have you ever been in a controlling or abusive relationship? ☐ Yes ☐ No

Are there any current abuse or neglect concerns in your household? ☐ Yes ☐ No

Please explain: ___

*Please note, control or abuse can be physical, sexual, verbal, or financial in nature.

Community Supports

Would you describe yourself as involved within your community? ☐ Yes ☐ No

If yes, please explain: ___

Are there any agencies or organizations you currently utilize for support? ☐ Yes ☐ No

If yes, please explain: ___

Religious/cultural identification: ___

Are you affiliated with a religious/spiritual group or institution: ☐ Yes ☐ No

If yes, please explain: ___

Describe any cultural factors which will help JFS provide an individualized level of service: i.e. religious observance, ethnicity, LGBTQ identity, socioeconomic factors, immigration factors, etc.: ___

___

Client signature: ___ **Date:** ___

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

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