A NEW DAY COUNSELING CENTER
Western Seminary
5511 SE Hawthorne Blvd.
Portland, OR 97215
Phone: 786-A-NEW-DAY

Personal History Information

Name:_____
First Middle Last

Sex: _____ Birthdate: _____ Current Age: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Is it okay to leave a message at: home? _____ cell? _____ work? _____

Address: _____

City: _____ State: _____ Zip: _____

Circle One: House Apartment Room Hotel Other:_____

Marital Status(circle one): Single Engaged Married Divorced Separated
Living Together Remarried Widowed

Spouse/Partner's Name: _____

In case of emergency contact:_____

Phone:_____ Relationship:_____

Referred by: _____

People who currently live in your household:

Name	Sex	Age	Relationship

Religious affiliation and/or preferred church, mosque, or place of gathering:
_____

For Office Use Only:

_____ _____ ☐ Individual ☐ Couple ☐ Family ☐ Group
Date of Term Name of Counselor

_____ _____ ☐ Individual ☐ Couple ☐ Family ☐ Group
Date of Term Name of Counselor

_____ _____ ☐ Individual ☐ Couple ☐ Family ☐ Group
Date of Term Name of Counselor

See also: _____

Children or Stepchildren not currently living with you:

Name	Sex	Age	Relationship

Reasons for seeking help at this time:

_____

_____

_____

_____

_____

How long have you been troubled by these concerns: _____

_____

_____

Who else is aware of your problem (s)? _____

_____

What would you like to have happen as a result of counseling? _____

_____

_____

PLEASE CHECK EACH ITEM WHICH IS OF CONCERN TO YOU PERSONALLY:

___Loneliness
___Memory impairment
___Depression
___Energy
___Inferiority
___Work
___Concentration
___Anger
___Children
___Nervousness/worry
___Legal matters
___Nightmares
___Alcohol use
___Separation
___Aggression/fighting
___Avoiding people
___Distractibility
___Gambling
___Impulsivity
___Phobias/fears
___Panic attacks
___Mood swings
___Unhappiness
___Shyness
___Career
___Education
___Temper
___Discipline
___Stress
___Finances
___Dreams
___Recurring thoughts
___Marriage
___Arguments/conflicts
___Computer addiction
___Eating disorder
___Hallucinations
___Irritability
___Health Problems
___Sleep-too little/much
___Suicidal thoughts
___Tiredness
___Making decisions
___Ambition-little/much
___Relaxation-little/much
___Self-control
___Being a parent
___Sexual addiction
___Friends
___Memories
___Drug use
___Sexual problems
___Anxiety
___Disorientation
___Elevated mood
___Hopelessness
___Judgment errors
___Other: _____

Briefly describe how the above checked symptoms impair your ability to function effectively:

Describe your life in general: (Circle One)

Very happy, happy, average, unhappy, very unhappy

Describe your life in the last six months: (Circle One)

Very happy, happy, average, unhappy, very unhappy

My greatest fear is: _____

My greatest hope is: _____

Family Life:

Your Family When You Were A Child

___Abuse, physical	___Excess work	___Physical illness
___Affectionate	___Fighting	___Poverty
___Alcoholism	___Frightening	___Prejudice
___Angry	___Mental illness	___Rigid
___Close	___Moved a lot	___Sexual abuse
___Cold	___Neglectful	___Supportive
___Competitive	___Overprotective	___Trusting
___Emotional abuse	___Depression	___Anxiety

___Other: _____

Place of birth:_____ City of childhood residence:_____

Father's name: _____ Occupation: _____

Describe relationship to father:_____

Is father living? No/Yes Age:___ Is mother living? No/Yes Age:_____

Mother's name: _____ Occupation: _____

Describe relationship to mother:_____

How did your parents get along in their marriage?_____

_____

Is your mother remarried? Number of times_____

Is your father remarried? Number of times_____

How many places did you live before completing high school? _____

Where are you in birth order? 1 2 3 4 5 6 7 8 9 10 11

List first names of brothers and sisters	# of years younger or older than you	Relationship- brother/ sister, step, 1/2, or full

Please list any deaths in your family and your age at the time:

_____

_____

Please list any divorces in your family and your age at the time:

_____

_____

Please circle last year completed in school:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Other: _____

Average grades in school: _____

Military Service:

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

Branch of service:_____ Date enlisted/drafted:_____

Discharge date:_____ Type of discharge:_____ Rank at discharge:_____

Combat experience? Yes/No Other stressors experienced:_____

Legal:

Have you ever had any legal difficulties? Yes / No

Describe:_____

Past history:

Traffic Violations: Yes/No DUII/DWI, etc: Yes/No

Felony/Misdemeanor charges: Yes/No Civil/custody lawsuits: Yes/No

Employment::
Your current employment: _____

How long employed/unemployed?_____

Have you changed jobs frequently? Yes / No

Approximate household income $_____ per _____

Health Information:

Overall condition: very good good average poor

Height: _____ Recent weight gain or loss: _____

Last physical exam: _____ Report: _____

Physician's name, address, and phone number: _____

_____

List any surgeries, accidents, or serious illnesses & dates:

_____

_____

Current medications: ___None

Medication:	Dosage:	Date First Prescribed:	Prescribed By:
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Current over-the-counter medications: ___None (includes vitamins, herbal remedies,etc.)

_____

Allergies and/or adverse reactions to medications: Yes/No
If Yes, please list:_____
_____

Please check all that apply to you:
___Anorexia/bulimia ___Headaches ___Stomach Problems

___Back pain
___Blackouts
___Burning/itchy skin
___Chest pains
___Constipation
___Diarrhea
___Dizziness
___Don't like to be touched
___Dry mouth
___Excessive sweating
___Fainting spells
___Fatigue
___High blood pressure
___Hearing problems
___Indigestion
___Muscle spasms
___Nausea
___Overeating
___Palpitations
___Poor appetite
___Rapid heart beat
___Sexual problems
___Skin problems
___Sleeping too much
___Sleeplessness
___Appetite/Weight
___Tension
___Tics
___Tingling
___Tremors
___Twitches
___Unable to relax
___Visual disturbances
___Vomiting
___Watery eyes
___Weight loss
___Weight gain
___Flushes
___Other: _____

Have you suffered from any of the following medical conditions during your lifetime?

___A serious accident
___A head injury
___High fevers
___Vision problems
___Ear infections
___Stomachaches
___Abortion
___Cancer
___Seizures
___Surgery
___Meningitis
___Hearing problems
___Asthma
___High blood pressure
___Diabetes
___Chronic pain
___Heart problems
___Other:_____
___Allergies
___Hospitalizations
___Headaches
___Loss of consciousness
___Pregnancy/miscarriage
___Speech/language problems
___A sexually transmitted disease
___Thyroid problems

Please describe any of the above checked items noting your age at the time of onset:

List any <u>current</u> health concerns:

Substance Use:
Please list anyone in your family of origin or current family who used or uses alcohol or drugs (prescription or on the street):

Relationship to You	Types of Drug	Purpose	For How Long

What alcoholic drinks did/do you use? _____

How much?_____ How often?_____ Last use?_____

What street drugs did/do you use? (Marijuana, Cocaine/Crack, PCP/LSD, Heroin/Opiates, Methamphetamines, Inhalants, Other)_____

How much?_____ How often?_____ Last use?_____

Do you smoke? ____ How much? _____ How often?_____ Last smoke? _____

Have you had withdrawal symptoms when trying to stop using any substances? Yes/No
If Yes, please describe the situation:_____
_____
_____
_____

Have any substances created a problem for you at work or home? Yes/No
If Yes, please describe the situation:_____
_____
_____
_____

Mental Health History:
Have you ever had a "nervous breakdown" or emotional problem?

Yes / No When? _____

Have you ever been in counseling, psychotherapy, or treatment?

Yes / No When? _____ With whom? _____

Was it helpful? _____

Have you ever attempted suicide? Yes / No
Give details:
_____
_____
_____

Do you ever have hallucinations? Yes / No

Do you ever hear voices other don't hear? Yes / No

Do you have any overwhelming fears?_____

Do you ever have panic attacks? _____

Do you ever intentionally injure yourself (i.e. cutting or burning)? _____

Do you have a desire to harm or injure someone other than you? _____

Please check if you have suffered any of the following types of trauma:

___ Neglect	___ Emotional abuse	___ Physical abuse
___ Sexual abuse	___ Loss of loved one	___ Natural disaster
___ Teenage pregnancy	___ Parental substance abuse	___ Crime victim
___ Violence in the home	___ Parents separated or divorced	___ Financial problems
___ Parental illness	___ Homelessness	___ Lived in foster home
___ Multiple family moves	___ Other:_____	

Please comment on any of the above checked items (including your age when the trauma occurred and the details of the traumatic event):_____
_____
_____

Spiritual and Cultural Issues:
Do you wish to discuss spiritual issues in counseling when relevant? Yes/No

How important is spirituality to you? Very important Somewhat important Not important

Are you aware of any spiritual resources or practices in your life that could be used to help you cope with or solve your problems? _____

To which cultural or ethnic group do you belong?_____

Are you experiencing any difficulties due to cultural or ethnic issues? Yes/No

If Yes, please describe:_____
_____

Your Personality:

Circle words which describe you best:

active ambitious self-confident persistent nervous hardworking impatient impulsive moody often-blue excitable imaginative calm serious easy-going sensitive lonely good-natured introverted extroverted likeable leader quiet submissive self-conscious

Other: _____

Relationships:
Please check each relationship item that is of concern to you:

___Affection
___Agreeing on chores
___Constant arguing
___Common interests
___Communication
___Infidelity
___Parenting
___Verbal fighting
___Conflict about children
___Closeness
___Housing
___In-laws
___Goals
___Finances
___Jealousy
___Relatives
___Anger
___Domineering spouse
___Showing appreciation
___Solving problems
___Sexual problems
___Feeling trapped
___Use of time
___Trusting each other
___Friendships
___Physical fighting
___Other: _____

When did you begin dating? _____

How long did you date your spouse prior to marriage? _____

How long have you been married/living together? _____

What do you like most about your partner? _____

What do you like least about your partner? _____

What do you like most about yourself? _____

What do you like least about yourself? _____

Describe any previous marriage/relationships: _____

_____

Children:

Please check concerns regarding your children:

___Abuse, physical
___Allergies
___Anger
___Arguing
___Attentivenss
___Bad dreams
___Bed wetting
___Complaining
___Depression
___Disobedience
___Drugs/Alcohol
___Fighting
___Friendships
___Health
___Hyperactive
___Immaturity
___Impulsive
___Jealousy
___Lying
___Moods
___Running away
___School
___Sexual abuse
___Sexual concerns
___Shyness
___Sleep
___Stealing
___Spouse/Ex interferes
___Swearing
___Temper tantrums
___Unhappiness
___Visitation arrangement
___Worrying/fears
___Other: _____

Please list any concerns you may have about beginning counseling: