Case Number:_____

WINKE COUNSELING SERVICES PC
ADULT PERSONAL HISTORY

Clients Name:_____Birthdate:_____

Reason for seeking treatment:_____

_____

Goals you would like to achieve during treatment:_____

_____

Family Information:

	Name	Sex	Age	Lives with you? Yes/No	Indicate if deceased
Spouse/ Significant other					
Children					
Mother					
Father					
Brothers / Sisters					

Case Number:_____

ISSUES THAT AFFECTED YOUR DEVELOPMENT (physical or sexual abuse, trauma -experienced or witnessed, nutrition, illness, neglect, etc.)

_____

_____

_____

ADULT RELATIONSHIP HISTORY

Sexual Orientation: ☐Heterosexual ☐Lesbian ☐Gay ☐Bisexual ☐Transgender

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

Your first marriage:_____/_____/_____/_____

Age Date No. of Children If deceased, give date

Your second marriage:_____/_____/_____/_____

Age Date No. of Children If deceased, give date

Check the best description of your relationship with your present significant other:
☐Excellent ☐Good ☐Fair ☐Poor

SOCIAL INFORMATION

Social time is usually spent: ☐Alone ☐Immediate Family ☐Peers
Please describe:_____

_____

Do you isolate yourself from other people?_____

CULTURAL/ETHNIC BACKGROUND

What is the ethnic group(s) of your parents?_____

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

Case Number:_____

LEGAL INFORMATION

Have you ever been involved with the police or courts? ☐Yes ☐No

If yes, please specify charge, date, result and if this was related to alcohol or other drug use:

_____

_____

_____

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

If yes, please explain:_____

MILITARY SERVICE

Have you ever served in the armed forces? ☐Yes ☐No

If yes, please include branch, enlistment date, discharge date, rank, and combat experience:

_____

_____

_____

EDUCATION

Highest grade completed:_____☐High School ☐GED ☐Some College ☐College Degree:

_____☐Graduate Degree:_____

Major Field

LEISURE/RECREATIONAL

Hobbies, leisure time activities, interests:_____

_____

Has your level of activity changed? ☐Yes ☐No If yes, explain how:_____

_____

EMPLOYMENT/VOCATIONAL HISTORY

Employers (most recent 1st)	**Dates**	**Job Descriptions**

Case Number:_____

Are you currently employed outside the home? ☐Yes ☐No ☐Full time ☐Part time

Special circumstances (underemployed, laid off, suspended, retired, etc):_____

_____

Family Income:_____Financial problems? ☐Yes ☐No If yes, explain:_____

_____

COUNSELING/PRIOR TREATMENT HISTORY

Have you had psychotherapy/counseling or attended a support group before? ☐Yes ☐No If yes, please list below:

Name of Center	Type of Service Outpatient/inpatient/Day Treatment	Dates	Drug or Alcohol Treatment (Y/N)

Have you ever experienced thoughts of harming yourself or another person?
☐Yes ☐No If yes, please explain:_____

Have you ever attempted to harm yourself or another person? ☐Yes ☐No
If yes, please explain:_____

Do you have a history of suicide attempts? ☐Yes ☐No If yes, please describe:_____

_____

Family history of emotional problems? ☐Yes ☐No

_____

Have you ever taken medications to treat mental health problems? ☐Yes ☐No
If yes, please list and indicate if they were effective or had any side effects.

_____

_____

Case Number:_____

CHEMICAL USE HISTORY

History of chemical use? ☐Yes ☐No If yes, please complete grid

Substance (circle or list)	Age at First use	Age at Regular use	Age at last use	Amount used In last 48 hrs.	Amount used in last 30 days
Alcohol Beer, wine, liquor					
Caffeine Coffee, energy drinks					
Nicotine Cigarettes,chewing tobacco, electronic cigarettes					
Cannabis Smoking, vaporizing, edibles, topical, tinctures					
Opiates/Prescription Pain Killers Heroin, Methadone, Suboxone, Oxycodone, Percocet, Vicodin					
Anti-anxiety Medications Xanax, Ativan, Klonopin, Valium, Ambien, other					
Amphetamines Methamphetamine, Ritalin, Adderall, diet pills,					
Cocaine Powder, crack					
Other Ecstasy, Molly, Spice, Cough Syrup, inhaled toxicants,LSD, Salvia, etc.					

Case Number:_____

Substance of Preference:
1._____2._____

Describe any changes in your use patterns:_____

_____

Family members with a past or present problem with drugs or alcohol?_____

_____

Do you have an increased tolerance to drugs or alcohol? Describe:_____

_____

Have you had withdrawals when you tried to stop using? ☐Yes ☐No
If yes, describe:_____

Does your temperament change when you drink? (Describe)_____

_____

Have you ever experienced blackouts? ☐Yes ☐No Ever overdosed? ☐Yes ☐No
Describe:_____

_____

Has your use negatively affected your life (job, relationship, legal)? ☐Yes ☐No
Describe:_____

_____

Other addictive behaviors? ☐Gambling ☐Spending ☐Sex ☐Other

Comment:_____

PHYSICAL HEALTH
Last date seen by physician and reason for seeing:_____

Medical Conditions (past & present, include surgeries, hospitalizations, and treatment procedures):_____

_____

Case Number:_____

Any history of head injuries, concussions, or traumatic brain injuries?

Current medications & dosages (include over the counter medications and supplements):

Are you allergic to or have had a bad reaction to any medications? ☐Yes ☐No If yes, please list:

If you are female, are you pregnant? ☐Yes ☐No If you are, or become pregnant, during treatment, it is important to inform your doctor if taking any medication.

Client Signature:_____ Date:_____

STAFF USE ONLY

Therapist Signature Date

Based on the information provided above, a physical exam ☐Is Required ☐Is Not Required

M.D./D.O. Comments_____

Physician Signature Date

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