DES MOINES THERAPY | AMES THERAPY
& CONSULTING SERVICES,PC

Personal History Questionnaire

Please complete all questions today. If you have questions while filling out this form, please ask. Thank You.

DEMOGRAPHICS:

Name: _____ Age: _____ Birth date: _____

(optional) Sexual Orientation: _____ (optional) Preferred Pronouns: _____

(optional) Race/Ethnicity:_____ (optional) Religious Affiliation: _____

Address: _____ State: _____ Zip: _____

Current Occupation and Employer: _____ Currently a student?: No ☐ Yes ☐

INSURANCE INFORMATION: Insurance: _____ Policy #: _____

Group #: _____ Company: _____

Primary Name on Insurance: _____ Primary Relationship to Client: _____

Primary Date of Birth: _____ Primary Phone Number: _____

Primary Insurance Holder Address: _____ State: _____ Zip: _____

MENTAL HEALTH:

PRESENTING PROBLEM/SEEKING COUNSELING FOR:

_____

_____

HISTORY OF PROBLEM: How long have you been experiencing symptoms: _____

_____

MENTAL HEALTH HISTORY: Have you ever been in mental health counseling? No ☐ Yes ☐

If yes, when and for how long? _____

HISTORY OF TRAUMA:

Do you feel that you experienced the following? ☐ Neglected ☐ Physically abused ☐ Sexually abused ☐ None

If yes to any, briefly explain (optional): _____

FAMILY MENTAL HEALTH HISTORY:

Any mental health history in family of origin? ☐ Parent ☐ Grandparent ☐ Sibling ☐ Extended family

Explain: _____

CURRENT MEDICATIONS: Please list all medications you are **currently taking** for mental health problems:

_____

PAST MEDICATIONS: Please list all medications you have taken **in the past** for mental health problems?

_____

Current OR Past Psychiatric Nurse Practitioner or Psychiatrist: _____ Phone: _____

Have you ever been hospitalized for mental health problems? No ☐ Yes ☐

If yes, please explain when and why: _____

MEDICAL HISTORY:

CONDITIONS & HISTORY: Please list all allergies: _____

Please list all physical illnesses/problems currently affecting you or you are currently being treated for:

_____

Please list all medications you are **currently taking** for physical problems:

_____

Have you ever had any head injuries involving a loss of consciousness? No ☐ Yes ☐

If yes, when and how long were you unconscious? _____

Current Doctor, Physician, Nurse Practitioner, Physician's Assistant: _____

Current Doctor's Office:_____ Phone/Address:_____

SUBSTANCE USE:

Do you currently use **OR** have used in the past:

☐ alcohol ☐ marijuana ☐ inhalants ☐ barbiturates ☐ amphetamines ☐ meth ☐ hallucinogens

How much? _____ How often? _____

Do you currently drink alcohol? No ☐ Yes ☐ If yes, how often? _____ _ How much? _____

EDUCATION & OCCUPATIONAL HISTORY:

Did you graduate from high school? No ☐ Yes ☐ If not, what is the highest grade completed? _____

Did you earn a GED? No ☐ Yes ☐ What were your usual grades in school (circle): Ⓐ Ⓑ Ⓒ Ⓓ Ⓕ

Did you ever repeat any grades in school? No ☐ Yes ☐ If yes, please explain:_____

Were you ever in special education/advanced classes in school? No ☐ Yes ☐ If yes, please explain:

_____

Were you ever suspended from school? No ☐ Yes ☐ If yes, please explain _____

Describe any current/past education beyond the traditional 12 years (technical, liberal arts, graduate school, etc.):

_____ If current: ☐ Full time or ☐ Part time

Major: _____ Year (expected) graduated: _____ ☐ Undergraduate ☐ Masters ☐ Doctoral

MILITARY HISTORY:

Were you ever in the military? No ☐ Yes ☐ If yes, which branch? _____ Number of years:_____

Highest rank attained _____ Type of discharge_____

LEGAL HISTORY:

Have you ever been arrested, jailed or imprisoned? No ☐ Yes ☐ If yes, please list charges & length of sentence:_____

SOCIAL HISTORY:

FAMILY HISTORY: How many brothers? ____ How many sisters? ____ In order of birth, which number child are you?___

Parents' marital status: ☐ Married ☐ Divorced ☐ Other: _____

Personal Relationship Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

How long have you been married? _____ Number of children with this partner? _____

If currently divorced, how long have you been divorced? _____ How long were you married? _____

Total number of children? _____

What type of home do you live in?

☐ House ☐ Apartment ☐ Assisted Living ☐ Trailer/Mobile Home ☐ Other_____

Who do you live with? _____

Do you drive? No ☑ Yes ☑ Do you require physical assistance to obtaining medical care? No ☐ Yes ☐

Do you require assistance in regards to taking medications? No ☐ Yes ☐

On average how many days per week do you exercise? ☐ 5-7 ☐ 3-4 ☐ 1-2 ☐ 0

How many hours of sleep do you normally get? _____

EMERGENCY CONTACT:

Name: _____ Relationship to Client: _____

Phone Number: _____

Completed by: _____ Date: _____