Daylight Counseling, PLLC

Assessment/Personal History Form (Ages 18 & Older)

Please take your time and fill out the entire form. Information you give us will help your therapist understand you better. You may use the backside if needed. Thank you.

Your Name:____ Age: ______ Date: ________________________

	Full Name	Age	Living with You	If Deceased, Year & Cause
Father:				
Mother:				
Spouse/Partner				
Child: 1				
Child: 2				
Child: 3				
Child: 4				
Child: 5				
Who else lives with you other than the ones checked above?				

Current Marital Status	Months / Years	Current Marital Status	Months / Years
Unmarried		Separated	
Living Together		Divorced	
Married		Widowed	

Who were you raised by: _______________________________________Were you adopted:__________________

Age first married: ___ Number of times married: ___ or lived with partner: ___Number of times divorced: ___ Number of Brothers living: ___ Deceased: ___ Sisters living: ___ Deceased: ___ How many are older than you: ___

Which family members are you close to now: ____

What recently happened to make you decide to seek help now: ____

____

____

What would you like this clinic to do for you:

____

____

EDUCATION:

Last grade completed: ______________________ Degree:___________________________ In School Now: ❑ Yes ❑ No

Special Training or skills: ____

Hope or Plan to go to school: ____

Do you have a learning disability: ❑ Yes ❑ No If Yes, explain: ____

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

❑ Allergies ❑ Hypoglycemia (low blood sugar) ❑ Low Blood Pressure ❑ Asthma ❑ Diabetes

❑ Head Injury ❑ Hypertension (high BP) ❑ Stomach problems ❑ AIDS ❑ STDs

❑ Pancreatitis ❑ Bacterial endocarditis ❑ Severe headache/migraine ❑ Lupus

❑ Liver Disease ❑ Prolapsed mitral valve ❑ Chronic Pain ❑ Hepatitis ❑ Insomnia

❑ Circulation Problems ❑ Injury from abuse ❑ Thyroid Problems ❑ Large Weight Gain ❑ Impotence

❑ Chronic Fatigue ❑ Large Weight loss ❑ High Cholesterol ❑ Appetite disturbance ❑ Ulcers

❑ Vision Problems ❑ Irritable Bowel ❑ Speech Problems ❑ HIV Positive ❑ Seizures

❑ Back Problems ❑ Hearing Problems ❑ Heart Disease ❑ Major Surgery ❑ Cancer

❑ Major Accidents: ____

Primary Physician's Name: ____

Physician's Address: ____ Phone:

Date of your last physical: _______________________________ Results:_______________

List all medications you are on for medical reasons: _________________________________

Do you skip meals often: ❑ Yes ❑ No Eat a well-balanced diet: ❑ Yes ❑ No

Do you eat much junk food: ❑ Yes ❑ No Do you exercise regularly: ❑ Yes ❑ No

FOR WOMEN:

Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Stillbirths: _____ Abortions: _____

Do you have normal menstrual cycles: ❑ Yes ❑ No Normal menstrual flow: ❑ Yes ❑ No

Are you pregnant: ❑ Yes ❑ No Premenstrual Syndrome: ❑ Yes ❑ No Menopause: ❑ Yes ❑ No

INTEREST ACTIVITIES: (What do you enjoy doing)

❑ Television ❑ Be with friends ❑ Shop ❑ Movies/Video

❑ Be with family ❑ Go to School ❑ Sew/Knit/Crochet ❑ Video Games

❑ Be alone ❑ Study ❑ Build/Decorate ❑ Music Listening

❑ Cook ❑ Get High ❑ Gardening ❑ Eat

❑ Exercise ❑ Photography ❑ Sing ❑ Play Sports

❑ Care for Elderly / Ill ❑ Dance ❑ Volunteer work ❑ Watch sports

❑ Child-care ❑ Read ❑ Travel/Site-see ❑ Hike

❑ Play Cards ❑Write ❑ Pray/Read Bible ❑ Gamble

❑ Draw ❑ Church Activities ❑Roller-blade/skate ❑ Sex

❑ Fix/Repair things ❑ Play Instrument ❑ Go to Museum _____________ ❑ Other: ________

Have you recently lost interest in activities you normally enjoyed: ❑ Yes ❑ No

EMPLOYMENT:

What do you do for a living: ____

Current employer: ___________________________Title: ____________________________ Years on the job:

Pay rate: _______________ Have you ever been fired from a job: ❑ Yes ❑ No If yes, how many times:

Reasons:____

Do you have any problems on current job: ❑ Yes ❑ No If yes, explain: ______________________________

____

FINANICAL:

Do you have any financial problems: ❑ Yes ❑ No If yes, explain: _________________________________

What types of financial aid do you receive: _____________________________________Monthly amount:

What types of aid do other household members receive: __________________________Monthly amount:

LEGAL HISTORY:

Arrest Date	Charge	Convicted	Sentence

Are you currently on Probation: ❑ Yes ❑ No Parole: ❑ Yes ❑ No Ending Date:

Are you involved in any lawsuits: ❑ Yes ❑ No If yes, explain: ___________________________________

Do you have any upcoming Court Dates: ❑ Yes ❑ No If yes, explain: ______________________________

MILITARY SERVICE:

Type: ____ When: _____________

Type of Discharge (Explain if Dishonorable): ______________________________________

Describe any combat experience: ____

Are you troubled now by your military experience: ❑ Yes ❑ No If Yes, explain:

ETHNIC/CULTURAL BACKGROUND:

Do you have any ethnic or cultural concerns: ❑ Yes ❑ No If Yes, explain:

____

RELIGIOUS/SPIRITUAL BACKGROUND:

Current religious/spiritual involvement/activities:

Do you have any religious or spiritual concerns: ❑ Yes ❑ No If Yes, explain:

____

SEXUAL/GENDER ISSUES:

Do you have any sexual or gender concerns: ❑ Yes ❑ No If yes, describe your concerns:

____

SYMPTOMS:

Current Presenting Problem(s) Onset:

____

____

Background History of Presenting Problem:

____

____

PLEASE CIRCLE ALL THAT APPLY:

	Past		Present	
Suicidal:	ideations/attempts/NA		ideations/attempts /NA	
Homicidal:	ideations/behavior/NA	victim/perpetrator	ideations/behavior/NA	victim/perpetrator
Domestic Violence:	yes/no	victim/perpetrator	yes/no	victim/perpetrator
Workplace Violence:	yes/no	victim/perpetrator	yes/no	victim/perpetrator

EATING AND BODY IMAGE RELATED BEHAVIOR:

❑ Normal ❑ Negative body image _______ ❑ Distorted body image ______________________

Restrictive eating: ❑ Mild ❑ Moderate ❑ Severe

❑ Generalized excessive eating ❑ Intermittent binge eating ❑ Frequent binge eating ❑ Purging

❑ Vomiting ❑ Laxatives ❑ Exercise diet pills ❑ Diuretics______ ❑ Other: _______________________

Details (frequency, body weight, physical symptoms, etc.): ____

DEPRESSIVE/BIPOLAR MOOD AND AFFECT ISSUES:

❑ None ❑ Dysphoria ❑ Crying episodes ❑ Hopeless/helplessness ❑ Suicidal Ideation

❑ Euphoria ❑ Rapid/pressured speech ❑ Loneliness ❑ Emptiness

Onset ________________________ Frequency_________________________ Duration ______________________

PERCEPTION OF SELF:

❑ Normal ❑ Low self-esteem ❑ Self-criticism/guilt/shame ❑ Grandiose

ENERGY:

❑ Normal ❑ Low energy/fatigue ❑ Elevated energy ❑ Agitated energy ❑ Restlessness

MOTIVATION AND ENGAGEMENT:

❑ Normal ❑ Low motivation ❑ Falling behind w/academics ❑ Procrastination

❑ Decline in self-care ❑ Interpersonal withdrawal and isolation ❑ Impulsivity

❑ Sometimes not attending class ❑ Frequently not attending class ❑ Has stopped attending class

❑ Increased/excessive goal-directedness ❑ Excessive involvement in pleasurable/dangerous activities

SLEEP:

❑ Normal ❑ Difficulty falling asleep ❑ Difficulty sustaining sleep ❑ Early morning awakening

❑ Excessive sleep ❑ Daytime napping ❑ Decreased need for sleep ❑ Delayed sleep cycle

❑ Nightmares

Typical time asleep: _______________Typical time awake:______________ Recent changes ___________________

SEXUALITY/SEXUAL ORIENTATION ISSUES:

❑ Normal ❑ Depressed libido ❑ Elevated libido ❑ Addiction/compulsivity ❑ Conflicted about sexual issues

ATTENTION / CONCENTRATION:

❑ Normal ❑ Generalized difficulties with attention and concentration ❑ Academic/learning related difficulties

❑ Easily distractible ❑ Difficulty sustaining mental effort ❑ Difficulties with planning and organization

❑ Frequently losing or misplacing things ❑ Frequent forgetfulness ❑ Frequent indecisiveness

ANGER:

❑ None ❑ Yelling ❑ Push/Hit/Choke Someone ❑ Throwing/Breaking things/Punching Walls

❑ Difficulties keeping relationships due to anger ❑ Difficulties keeping a job due to anger

❑ Increased Anger when under stress ❑ Known/Unknown anger triggers

❑ Is your partner sometimes afraid of you ❑ Are your children afraid of you sometimes

ANXIETY:

❑ Normal ❑ Generalized excessive worry ❑ Difficulty relaxing ❑ Worries/anxieties over specific issues:

❑ Financial worries ❑ Fear of Dying ❑ Obsessive Thoughts: ____

❑ Compulsive behaviors:

❑ Panic ❑ Rapid heart rate ❑ Rapid breath/hyperventilation ❑ Dizziness/feeling faint
❑ Sweating ❑ Chest pain ❑ Trembling/shaking ❑ Nausea/abdominal distress
❑ Feeling overwhelmed/terrified ______ ❑ Other symptoms: ____________________

Onset ____________________ Frequency ____________________ Duration ____________________

❑ Social discomfort ❑ Generally shy ❑ Social avoidance ❑ Discomfort with large groups
❑ Discomfort with opposite sex ❑ Extreme discomfort with public speaking/class presentations

TRAUMA/DISSOCIATIONS:

❑ None ❑ Intrusive thoughts/images ❑ Flashbacks/reliving of trauma
❑ Physiologic hyper-activity ❑ Affective numbing ❑ Avoidance of trauma-related stimuli
❑ Trauma-related nightmares ❑ Hyper vigilance ❑ De-realization/depersonalization
❑ Dissociative episodes

When? ____________________

SUBSTANCE USE ISSUES:

	Past	Occasional	Problematic	**Present**	Occasional	Problematic
Alcohol:	❑	❑	❑	❑	❑	❑
Nicotine:	❑	❑	❑	❑	❑	❑
Cannabis:	❑	❑	❑	❑	❑	❑
Cocaine/Crack:	❑	❑	❑	❑	❑	❑
Heroine/Methadone:	❑	❑	❑	❑	❑	❑
Amphetamines:	❑	❑	❑	❑	❑	❑
Pain Killers:	❑	❑	❑	❑	❑	❑
Prescription Meds:	❑	❑	❑	❑	❑	❑
Inhalants:	❑	❑	❑	❑	❑	❑
Steroids:	❑	❑	❑	❑	❑	❑

❑ Client acknowledging substance use difficulties ❑ Client minimizing substance use difficulties

Onset ____________________ Frequency ____________________ Duration

Has your drinking or drug usage ever caused you problems in any of the following areas:

❑ Family ❑ Employment ❑ Legal ❑ Emotional ❑ Social ❑ Financial ❑ Behavior

PHYSICAL/MEDICAL:

Does a relative, loved one, friend, court or employer feel you have an alcohol or drug problem: ❑ Yes ❑ No

PREVIOUS MENTAL HEALTH OR ALCOHOL/SUBSTANCE ABUSE TREATMENT:

Outpatient: Have you seen a therapist /counselor for personal or family problems or alcohol/drug treatment:

❑ Yes ❑ No If yes, when and where: ____________________

Reason: ____________________

Any involvement in self-help support groups such as AA, NA, ACOA, CODA, RR, EA, AIM, ISA, Recovery: ❑ Yes ❑ No

If yes, when and where: ____________________

Reason: ____________________

Inpatient: Have you been in a hospital or residential treatment for personal problems or alcohol/drug problems:

❑ Yes ❑ No If yes, when and where: ____________________

Reason: ____________________

Were any of your treatment experiences helpful? ❑ Yes ❑ No If yes, explain: ____________________

What medications were prescribed: ____________________

Which of those medications were helpful: ____________________

Have any family members been hospitalized for personal or substance abuse problems: ❑ Yes ❑ No

If yes, who, when, where: ____________________

Childhood Experiences Worksheet

A. Circle the negative characteristics of your parents. List any additional items.

Controlling	Distant	Over protective
Judgmental	Verbally Abusive	Immature
Angry	Physically Abusive	Too Busy
Lazy	Alcoholic	Workaholic
Uncaring	Drug Addict	Mean
Intolerant	Smothering	Unemotional
Unforgiving	Distrustful	Argumentative
Irresponsible	Accusatory	Overbearing
Unstable	Unpredictable	Selfish

____

B. Circle the positive characteristics of your parents. List any additional items.

Happy	Caring	Kind
Loving	Fun	Interested
Forgiving	Genuine	Involved
Truthful	Warm	Wise
Empathic	Compassionate	Graceful
Trustworthy	Stable	Generous
Understanding	Respectful	Consistent
Balanced	Healthy	Friendly

____

C. Circle how you felt when you think of your positive childhood experiences and memories. List any additional items.

Warm	Loved	Cared for
Safe	Happy	Free
Comfortable	Relaxed	Special
Grateful	Good	Connected
Whole	Full	Capable
Valued	Important	Complete

____

D. Circle how you survived and coped with your negative childhood experiences. List any additional items.

Cried	Hid	Left
Avoidance	Friends	Rebelled
Isolated	Withdrew	Acted Out
Persevere	Seek outside help	Hobbies
Music	Read	Pray
Humor	Self Soothing	Alcohol/Drugs

____