



PERSONAL HISTORY FORM

SECTION I: Client Information

Client ID #: _____ Date: _____ DX: _____
(For Office Use Only)

Name of Client: _____ Age: _____ DOB: _____

Social Security Number: _____ Referred by: _____

Address: _____

Home Phone: _____ Work Phone: _____ Other: _____

May I leave a message at home? Yes ___ No ___ At work? Yes ___ No ___ On cell? Yes ___ No ___

Email Address: _____

Place of Employment: _____

Occupation: _____ Hours Worked: _____

Relationship Status: Single ___ Married ___ Partnered ___ Divorced ___ Widowed ___

Other _____

Name of spouse/partner or closest friend or relative to you: _____

Relationship (if other than spouse/partner): _____

Phone Number: _____ Place of Employment: _____

Chief complaint or issues you are concerned with: _____

List any major health problems for which you currently receive treatment: _____

List all medications you are currently taking: _____

Current prescribing physician/psychiatrists: _____

Have you ever received psychiatric help or counseling of any kind before? _____

If so, when and with whom? _____

What issues were addressed? _____

Do you use alcohol? (mark one) Never ___ Occasionally ___ Often ___ Daily ___

Do you use drugs? (mark one) Never ___ Occasionally ___ Often ___ Daily ___

How is your physical health? Excellent ___ Good ___ Fair ___ Poor ___

SECTION II: Identification of Symptoms

Please rate all responses based on level of distress or concern.

- | 1
None | 2 | 3
Moderate | 4 | 5
Extreme |
|--|---|---------------|---|---|
| 1. Ambition _____ | | | | 25. Emotional abuse _____ |
| 2. Career choices _____ | | | | 26. Accident, trauma, assault _____ |
| 3. Fears _____ | | | | 27. Sexual harassment _____ |
| 4. Unrealistic self-expectations _____ | | | | 28. Sexual abuse as a minor _____ |
| 5. Making decisions _____ | | | | 29. Rape/Sexual assault _____ |
| 6. Concentration/Memory _____ | | | | 30. Sexual identity concerns _____ |
| 7. Coping skills _____ | | | | 31. Adjustment to major life changes _____ |
| 8. Sleep difficulties/Insomnia _____ | | | | 32. Depression _____ |
| 9. Lack of intimate relationships _____ | | | | 33. Irritable/angry feelings _____ |
| 10. Conflicts in intimate relationships _____ | | | | 34. Anxiety/stress _____ |
| 11. Physical violence in intimate relationships _____ | | | | 35. Panic attacks _____ |
| 12. Loss of intimate relationships/Divorce _____ | | | | 36. Obsessive thoughts/compulsive behavior _____ |
| 13. Parenting _____ | | | | 37. Thoughts of suicide _____ |
| 14. Family Conflicts _____ | | | | 38. Past attempts of suicide (yes or no) _____
of attempts (if none, put zero) _____ |
| 15. Family member with alcohol or substance abuse _____ | | | | 39. Impulsive behavior _____ |
| 16. Lack of social contact/shyness _____ | | | | 40. Bizarre or strange thoughts _____ |
| 17. Commitment issues _____ | | | | 41. Self mutilation _____ |
| 18. Death or impending death of a friend, family member or partner _____ | | | | 42. Severe premenstrual syndrome (PMS) _____ |
| 19. Religious /Spiritual concerns _____ | | | | 43. Pregnancy/abortion concerns _____ |
| 20. Multicultural issues/concerns _____ | | | | 44. Infertility _____ |
| 21. Financial concerns _____ | | | | 45. Sexually Transmitted Disease _____ |
| 22. Legal concerns _____ | | | | 46. AIDS/HIV issues (self, friends, family) _____ |
| 23. Low self-esteem _____ | | | | 47. Weight concerns/body image issues _____ |
| 24. Feelings of extreme loneliness _____ | | | | 48. Health Concerns _____ |
| | | | | 49. Serious illness, past or present _____ |

Which #'s above are of most concern?

Most important is # _____
 Next important is # _____
 Next important is # _____

SECTION III: Responsible Party (complete only if client is younger than 18 years old)

Father's Name: _____ Date of Birth: _____
Father's Employer: _____ Work Phone: _____

Mother's Name: _____ Date of Birth: _____
Mother's Employer: _____ Work Phone: _____

Parent's Home Phone Number (if different from client's): _____
Parent's address (if different from client's): _____

SECTION IV: Insurance Information

If you believe your insurance may cover a portion of your visits here, please complete the following information (please read "Client Services Contract" carefully):

Insurance Company: _____

Address: _____

Insurance Plan Name: _____

Phone Number of Insurance Company: _____ ID Number: _____

Policy Number: _____ Group Number: _____

Name of Policy Holder (if different from client): _____

Policy Holder's Date of birth (if different from client): ____/____/____

Address of Policy Holder (if different from client): _____

Policy Holder's Place of Employment: _____

Relationship of insured to client (if applicable): _____

Secondary Insurance Company (if applicable): _____

Address: _____

Insurance Plan Name: _____

Phone Number of Insurance Company: _____ ID Number: _____

Policy Number: _____ Group Number: _____

I give permission for Betty-Shannon Prevatt, MA to release any information obtained throughout the course of my treatment to my insurance company.

Signature: _____ **Date:** _____

I understand that Betty-Shannon Prevatt, MA may file my insurance as a courtesy, but that the fee for services is my responsibility. I agree to pay in full for my sessions at the time of service unless another payment agreement has been made in writing.

Signature: _____ **Date:** _____