LAKE MONONA CENTER
Psychotherapy & Recovery

Personal History Form

Please check areas in which you've noted difficulties or changes

❑ Sleep ❑ Appetite ❑ Crying ❑ Concentration ❑ Weight
❑ Sexual Activity ❑ Physical pains ❑ Sickness ❑ Panic
❑ Unusual behavior ❑ Depressive thinking ❑ Frightening thoughts
❑ Social interaction ❑ Suicidal thoughts

Have you previously been in therapy? ❑ Yes ❑ No

Please check issues that pertain to past treatment

❑ Anxiety ❑ Depression ❑Relational ❑ Parenting
❑ Chemical abuse/dependency ❑Original family/Adult Child
❑ Sexual abuse ❑ Other ________________________________

Please list previous clinic / therapist(s) and dates ______________________________________
____

Your current health ____

Are or have you recently been on any medication? ❑ Yes ❑ No

List type and dosage ____

Physician's Name and address ____

Have you ever been hospitalized? ❑ Yes ❑ No

Dates and reason ____

Do you use alcohol?❑ Yes ❑ No Tobacco? ❑ Yes ❑ No

Amount and frequency ____

Please check any of the following that are applicable. Do you use or have you used?

❑ Tranquilizers (Valium, Librium, Xanax, etc.) ❑ Narcotics ❑ Cocaine
❑ Marijuana ❑ Amphetamines ❑ Other__________________________

Family History

Where did you grow up? ____

Father

Name_____________________________Age____Occupation__________________________

Health____

Location/Living Arrangement____

Divorces/Remarriage____

If deceased, age, year, cause of death____________________________________

Mother

Name_____________________________Age____Occupation__________________________

Health____

Location/Living Arrangement____

Divorces/Remarriage____

If deceased, age, year, cause of death____________________________________

Older Siblings ____

Younger Siblings ____

(Please include any deceased siblings)

Do illness or disorders tend to run in your family? ❑Yes ❑No

Have any of your family (Grandparents, parents, parents' siblings, your siblings, children) had or might have had problems with the following?

	Relative	Treatment
Alcohol / drug abuse		
Depression		
Bi-polar disorder		
Suicide		
Other emotional disorders		

What is your present living situation? ❑ Single ❑ Married

❑ Partner ❑ Divorced ❑ Separated ❑ Widowed

Length of marriage / relationship ______________________________________

Spouse / Partner's Name ___________________________Age ______________

Education ______________________ Occupation ___________________________________

Previous Marriages ____

Children from previous marriage ____

Have you ever been previously married? ❑Yes ❑No

Dates of previous marriage(s) ____

Children	Age	Living arrangement
________________________	_____	____
________________________	_____	____
________________________	_____	____
________________________	_____	____

If any children are deceased please give age and cause of death.

Any difficulties / concerns with children? _______________________________________

Have you been in the Armed Forces? ❑Yes ❑ No

Please list branch, dates, type of discharge ____

Check the education level you've completed ❑6th ❑7th ❑8th ❑9th ❑10th ❑11th ❑12th ❑13th ❑14th ❑15th ❑16th ❑More __________________

Degrees received ____

Other education / training ____

Present occupation ____

How long have you been with this job? ____________________

Are you satisfied with this job? ❑ Yes ❑ No

Religious upbringing ____

Are you presently active in a church or spiritual program? ____________________________

Please list any hobbies or special interests you have

____

____

How do you spend your free time? ____

Do you have a supportive circle of friends that you spend time with? ❑ Yes ❑ No

Is there any other information we should have about you or your family regarding your treatment here?

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