



Your Advocate for Life/Work Strategies

PERSONAL HISTORY FORM
(Completed by Client)

Date ____/____/____

Name _____

Social Security # _____

Date of Birth ____/____/____

What concern(s) brings you to counseling? _____

What changes do you want to see as a result of counseling? _____

Previous Counseling, EAP or Chemical Dependency Services:

Counselor	Date	Reason	Helpful?
1			
2			
3			

Household Members:

Name	Age	Relationship	Are you the legal custodian/guardian?
1			
2			
3			
4			
5			

Medical History

Are you currently under a doctor's care?		Yes	No	Health Problems: (include allergies)
	: date of last physical exam			
	: name of Primary Care Physician			
	: other doctor(s) involved in your care			

Medication currently using: (if none, state none)

Medication	Dosage	Doctor Prescribing	Reason Prescribed

Past Hospitalizations – Medical, Psychiatric, Chemical Dependency:

Date	Reason	Hospital