Welcome to Bear River Mental Health Services, Inc. As an important part of your assessment appointment, we ask that you fill out the following information packet as completely as possible. Completion of this packet will greatly assist your therapist in gathering information about your history and developing the assessment and treatment plan.

This packet will be used for informational purposes only and is not considered part of the clinical record. This information will be destroyed after it has been reviewed by the therapist.

If you have questions, please contact our service coordination staff at the appropriate location.

Cache and Rich Counties: 435-752-0750

Brigham City: 435-734-9449

Tremonton Area: 435-257-2168

# ADULT PERSONAL HISTORY

**Client Legal Name** ___________________________________ **Date** _________________________________

**Client Preferred Name** _______________________________ **Client Preferred Pronoun** ________________

## PRESENTING PROBLEMS

Please list the problems or difficulties for which you are seeking help. Begin with the problem that is bothering you most.

1. ________________________________________________________________________________

   Rate the severity of problem #1 ___mild ___ moderate ___severe Length of problem _____________

2. ________________________________________________________________________________

   Rate the severity of problem #2 ___mild ___ moderate ___severe Length of problem _____________

What solutions have you already tried to correct the main problem? _______________________________________

________________________________________________________________________________

## DESIRED OUTCOMES OF SERVICE

What do you hope to achieve by seeking services here? _____________________________________________

What are the current stressors/difficulties in your life?

| | | | |
|---|---|---|---|
| ____ your health | ____ housing | ____ communicating with others | ____ safety |
| ____ managing time | ____ finances | ____ eating/drinking habits | ____ solving problems |
| ____ family | ____ alcohol/drug use | ____ leisure time | ____ getting help |
| ____ friends | ____ sex life | ____ being productive | ____ coping |
| ____ rules/behavior | ____ cleanliness | ____ self-care | ____ dress/appearance |

____ other, please list: ________________________________________________________________

**Current and Past Symptoms:** Please rate yourself on the following symptoms:

| | Never | Almost Never (ie. 1 day a week) | Some of the time (ie. 2-3 days) | Most of the time (ie. 4-5 days) | Almost all the time (ie. 6-7 days) |
|---|---|---|---|---|---|
| Appetite problems | ○ | ○ | ○ | ○ | ○ |
| Sleep problems | ○ | ○ | ○ | ○ | ○ |
| Weight gain or loss | ○ | ○ | ○ | ○ | ○ |
| Loss of interest in things | ○ | ○ | ○ | ○ | ○ |
| Problems concentrating | ○ | ○ | ○ | ○ | ○ |
| Guilt | ○ | ○ | ○ | ○ | ○ |
| Low self-worth | ○ | ○ | ○ | ○ | ○ |
| Hopelessness | ○ | ○ | ○ | ○ | ○ |
| Suicide thoughts | ○ | ○ | ○ | ○ | ○ |
| Explosive anger | ○ | ○ | ○ | ○ | ○ |
| Irritability | ○ | ○ | ○ | ○ | ○ |
| Anxiety and Stress | ○ | ○ | ○ | ○ | ○ |
| Mood swings | ○ | ○ | ○ | ○ | ○ |
| Hearing voices | ○ | ○ | ○ | ○ | ○ |

| Nightmares | ○ | ○ | ○ | ○ | ○ |
|---|---|---|---|---|---|
| Other, please list: ______________________ | ○ | ○ | ○ | ○ | ○ |

Length of your symptoms (consecutive months): ___0-1months ___2-5mths___6-12mths ___12+mths___2 yrs.+

**SUBSTANCE USE**

Do you drink alcohol? ___Never ___Rarely ___Sometimes ___Almost daily

If yes, what do you normally drink? ______________________________________________________________________

Have you ever smoked cigarettes or used ecigarettes? □ Yes □ No
Currently? □ Yes □ No If yes, how many packs per day on average? ________ How many years? ________
In the past? □ Yes □ No If yes, how many years did you smoke? __________When did you quit? _________

Use of pipes, cigars, or chewing tobacco: Currently? □ Yes □ No In the past? □ Yes □ No
What kind? _________________ How often per day on average? _______________ How many years? ________

Do you currently use any street drugs? ___Never ___Rarely ___Sometimes ___Almost daily

If yes, what kind? ______________________________________________________________________________

Do you take any medications that are not prescribed to **you**? ___Never ___Rarely___Sometimes ___Almost daily

If yes, what kind? ______________________________________________________________________________

Do you ever take prescription medication more frequently than prescribed? ___No ___Yes

If yes, please explain:___________________________________________________________________________

Have you used drugs in the past —what type and when? ___________________________________________________

_____________________________________________________________________________________________

Have drugs or alcohol ever contributed to any problems in your life? ___ Yes ___ No If yes, when? ___________

_____________________________________________________________________________________________

Have you ever received formal treatment for substance abuse?

When and Where? _____________________________________________________________________________

Treatment focused on what substance? ______________________________________________________________

Was the treatment inpatient/residential ___ outpatient ___ or both ___?

Have you ever been involved in a twelve-step group? (AA, NA, etc.) ____Yes ____No

**PSYCHOSOCIAL HISTORY**

**Childhood, Family and Developmental History**

Where were you born and raised? _________________________________________________________________

Were there any problems with your birth or development in early childhood—ie. slow to walk or talk, significant childhood illnesses, problems learning ?___________________________________________________________
Father's Name ___________________________________ Occupation ___________________________________
Divorced ___No ___Yes If yes, date __________ Deceased ___No ___Yes If yes, date ________________
How would you describe your father? _______________________________________________________________

Mother's Name ___________________________________ Occupation ___________________________________
Divorced ___No ___Yes If yes, date __________ Deceased ___No ___Yes If yes, date ________________

How would you describe your mother? ___________________________________________________________

Step-father's Name _________________________________ Occupation ___________________________________
Divorced ___No ___Yes If yes, date __________ Deceased ___No ___Yes If yes, date ________________
How would you describe your stepfather? _______________________________________________________

Step-mother's Name _________________________________ Occupation ___________________________________
Divorced ___No ___Yes If yes, date __________ Deceased ___No ___Yes If yes, date ________________
How would you describe your stepmother? _______________________________________________________

List your brothers and sisters, from oldest to youngest, including yourself, and show whether your relationship with each brother or sister has been negative or positive by circling the (+) for positive or the (-) for negative.

| **Sibling Relationships** | | | | |
|---|---|---|---|---|
| Brother or Sister | Age | Sex | Relationship Growing Up | Relationship Right Now |
| | | | + - | + - |
| | | | + - | + - |
| | | | + - | + - |
| | | | + - | + - |
| | | | + - | + - |
| | | | + - | + - |

What are the most pleasant memories from your youth? ______________________________________________

_____________________________________________________________________________________________

What are the unhappiest things you experienced growing up? ________________________________________

_____________________________________________________________________________________________

Please list any separations from your parents / care givers you may have experienced as a child (ie. placed in foster care, moved from family member to family member, incarceration of parent, death of a parent etc.): __________

_____________________________________________________________________________________________

Were there any problems in your family during your childhood regarding any of the following?
Check if any apply. discipline ___ communication ___ showing love ___

Explain:_______________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

## Marital Relationships

(A life partner is defined as someone whom you are living with in a committed relationship)

| | First Marriage | Second Marriage | Third Marriage |
|---|---|---|---|
| Name of spouse or life partner | | | |
| Partner's occupation | | | |
| Your age at time of marriage | | | |
| Partner's age at time of marriage | | | |
| Length of marriage in years | | | |
| Number of children by marriage | | | |
| If marriage has ended, was it by death or divorce? | | | |
| Year of death or divorce | | | |

Overall, how would you describe your present relationship with your spouse or partner?

___Excellent ___Good ___Average ___Fair ___Poor

Describe your present partner's strengths ____________________________________________

Describe his or her weaknesses ________________________________________________

Are there problems in your present relationship? (specify) _____________________________

_______________________________________________________________________________

**Relationships with Your Child/Children**

List your children, if any, from oldest to youngest and indicate whether your relationship with each is positive by circling (+) or negative by circling (-).

| Child | Age | Sex | Relationship Growing Up | Relationship Right Now | Living in Home |
|---|---|---|---|---|---|
| | | | + - | + - | ___ Yes ___ No |
| | | | + - | + - | ___ Yes ___ No |
| | | | + - | + - | ___ Yes ___ No |
| | | | + - | + - | ___ Yes ___ No |
| | | | + - | + - | ___ Yes ___ No |
| | | | + - | + - | ___ Yes ___ No |
| | | | + - | + - | ___ Yes ___ No |

Describe any specific parenting concerns: ______________________________________________

_______________________________________________________________________________

Describe any other family concerns: __________________________________________________

_______________________________________________________________________________

**HEALTH AND MEDICATIONS HISTORY**

Personal physician's name ________________________________________________

Date of last physical examination _______________ Date of last colonoscopy _______________

Specialist(s) you are presently seeing ____________________________________________

| **List any medications you have taken regularly, either in the past or present** | | | | | |
|---|---|---|---|---|---|
| Name of Drug | Dosage | Frequency | Prescribing Physician | Date Started | Date Discontinued |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Are you allergic to any medications, food, or inhalants? ___No ___Yes

If yes, list them ________________________________________________________________

List any operations (including dates--to your best recall) ___________________________________

_______________________________________________________________________________

Please indicate with a check whether you or a family member have had any of the following:

| Condition | You, in the past 3 months | You, more than 3 months ago | Family member |
|---|---|---|---|
| Severe headaches | | | |
| Convulsions or seizures | | | |
| Asthma | | | |
| Colitis | | | |
| High blood pressure | | | |
| Heart problems | | | |
| Cancer | | | |
| Diabetes | | | |
| Hypoglycemia | | | |
| Ulcers | | | |
| Premenstrual tension | | | |
| Thyroid problems | | | |

Do you have any other current medical problems? ______________________________________________

Have you ever had a head injury where you lost consciousness? ___ No ___ Yes If yes, please describe the circumstances: ______________________________________________

Do you suffer from chronic pain? ___No ___Yes How long have you had this problem? __________________

What is the site of your pain? ______________________________________________

Check immunizations you have had and the date the immunization was given:

| | |
|---|---|
| ☐ Tetanus Date given: | ☐ Pneumonia Date given: |
| ☐ Hepatitis A Date given: | ☐ Chickenpox Date given: |
| ☐ Hepatitis B Date given: | ☐ MMR Measles, Mumps, Rubella Date given: |
| ☐ Influenza Date given: | |

Do you exercise regularly? ☐ Yes ☐ No If yes, how often? ____________________________________

**Woman Only** –
Date of last pelvic exam and/or Pap smear ____________ Date of last mammogram ______________

Do you have:
☐ Menstrual problems? ☐ Significant childbirth related problems? ☐ Urine loss when you cough, sneeze or laugh?

## ABUSE / NEGLECT / TRAUMA HISTORY

Were you ever abused as a child? ___No ___Yes

Emotional abuse ___No ___Yes If yes, by whom? ____________________________________

Physical abuse ___No ___Yes If yes, by whom? ____________________________________

Sexual abuse ___No ___Yes Family member ___Yes ___No ___Uncertain

Have you ever been the victim of abuse as an adult? ___ No ___ Yes, physically ___ emotionally___ sexually

Explain: ______________________________________________

Have you ever been involved in any other type of traumatic incidents such as Medical Trauma, Natural Disasters, Refugee Trauma, Terrorism, Victim of a Crime, or Traumatic Grief? ○ No ○ Yes

Explain: ______________________________________________

**CULTURAL / ETHNIC INFORMATION**

Please list (describe) any information about yourself, your life, or your family that is unique to you that would be helpful for your therapist to be aware of, i.e. religious views/beliefs, family heritage, family traditions, cultural beliefs:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

___________________________________________________________________________

**EDUCATIONAL and EMPLOYMENT CHALLENGES/BARRIERS**

**Education History**:

Do you have any behavior or attention problems in school? ___ Yes ___ No

Is there any family history of the same problems? If so, who? ______________________________

Did you ever participate in resource classes? ___Yes ___No If yes, which areas did you have difficulty with?

___reading ___math ___writing ___science ___social studies

What is your highest level of education? **Please circle**: High school 9, 10, 11, 12

Vocational or technology school 1, 2, 3 College 1, 2, 3, 4 Graduate school 1, 2, 3, 4, 5

Degrees, certifications, or vocational licenses ________________________________________

Major field of study in college or vocational school _____________________________________

**Employment History**:

Do you currently consider yourself able to work? ______ If not, what situation or condition prevents you from doing so? ______________________________________________________________________

How many jobs have you had in the past five years? _____________________________________

What is your present occupation? (If homemaker or student, please indicate) _____________________

How long have you worked at your present job? _________________________________________

How would you rate your present job? ___ Excellent ___ Good ___ Average ___ Fair ___ Poor

**MENTAL HEALTH TREATMENT HISTORY**

Have you been treated or hospitalized for mental or emotional problems in the past? ___No ___Yes

If yes, please describe below:

| Where | When | Condition / Diagnosis treated | Doctor / Therapist |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Does anyone else in your family have a history of mental illness? ___No ___Yes

If yes, please explain:_______________________________________________________________

______________________________________________________________________________

**What is your CURRENT living arrangement?**

_____ Renting _____ Living in house you own
_____ Living with family _____ Living with friends
_____ Other (specify) ______________________________________

Would you say that this situation is stable for the next 3-6 months? ______________________________________
How long have you lived in the county you reside in? ____________________________________________________

Where did you live previously? _______________________________ Length of time there? ________________

## CRIMINAL / LEGAL HISTORY

Have you ever been arrested or charged with a crime? ___No ___Yes If yes, explain:
_____________________________________________________________________________________________

Have you served time in jail? ___No ___Yes Served time in prison? ___No ___Yes

Are you currently on probation or parole? ___No ___Yes Probation Officer_____________________________

**SUICIDE / OTHER RISK ASSESSMENT**

Have you ever been suicidal?
___Never
___Yes, I've wished I was dead or wouldn't wake up.
___Yes, I've had thoughts of killing myself but never made a plan.
___Yes, I have thought about a plan.
___Yes, I am feeling suicidal now.
___Yes, I have attempted suicide in the past. Please describe how and when:___________________________

_____________________________________________________________________________________________

Have you had any thoughts of hurting others recently? ___No ___Yes.

Do you have a history of assault? ___No ___Yes If yes, please explain. _________________________________

**STRENGTHS and NATURAL SUPPORTS**

What are your present interests, hobbies, and leisure time activities? ______________________________________

_____________________________________________________________________________________________

How often do you do social activities outside of work or school with other adults? Check the one that best applies: ___ Rarely ___ 1x month ___ 2-3x month ___ 1x week ___ 2x week +

Do you have relatives or close friends in whom you can confide? ___ Yes ___ No

Who? ___________________________________________________________________________________

How many close friends do you now have? _________________________________________________________

What would you say are your greatest personal strengths or skills? _______________________________________

_____________________________________________________________________________________________

jw\my docs\forms\clinical\personal history ADULT June 2020