COMPASS COUNSELING WAUSAU, LLC
CONSUMER PERSONAL HISTORY

Name_____ Age_____ DOB_____

Address_____ City _____State ___Zip_____

Phone Number: _____

Please briefly state why you scheduled this appointment and what you would like to personally gain from the experience: _____

_____

_____

EDUCATIONAL AND VOCATIONAL INFORMATION

Completed High School Grade Level _____GED/HSED? _____

Did you have any academic problems? _____

_____

Behavioral problems? _____

_____

Did you attend a technical college or university? _____

Name of School_____Major(s) _____Graduation Date_____

Employment Status: Unemployed _____ Employed Part Time_____ Full Time_____

Employer _____

Job Title_____ Length of Employment _____

Previous Employer_____ Length of Employment _____

Military Service ____ Yes ___ No Branch_____

Date of Service_____ Discharge Date _____

MARRIAGE AND FAMILY

Marital Status _____ Date of Marriage _____

Date of Divorce _____

Date of previous Marriage(s) _____

Date(s) of Previous Divorce(s) _____

Name of Spouse/Partner_____ DOB_____

Employer_____ Job Title_____

Names and Ages of Children Biological/Adopted Step or Partners?

Currently living with you:	Not Living with you:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

AODA INFORMATION

Do you drink alcohol? ____Yes ____No How much? ___Daily ___Weekly ___Monthly
Do you or anyone else believe this to be a problem? _____
Do you use tobacco products? ____Yes ____No Type/amount_____
Have you ever used illegal drugs? ____Yes ____No
Describe which drugs: _____
_____
Date of Use:_____ Current Status: _____
Has your spouse/significant other, children or any other family members or an extended family member (grandparents, etc.) experienced drug abuse/addiction problems?
_____
_____

MENTAL HEALTH INFORMATION

Have you ever been treated at an outpatient clinic or hospitalized for mental health problems or problems with relationships? If yes, please explain_____
_____

Name of Therapist	Name of Clinic/Hospital	Dates of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever thought about committing suicide? ___Yes ___No

Have you ever attempted to take your life? ___Yes ___No

Have you had any thoughts about suicide recently? ___ Yes ___ No

Have you ever been abused? ____Yes ____No

Please describe your mood over the last two weeks_____

MEDICAL HISTORY

Name of Physician _____

Physician's Address_____

Last seen by physician and reason _____

Have you had any surgeries, hospital stays or other serious illnesses? ___ Yes ___No

If yes, please explain when and why_____

_____

Please list medical problems and dates of treatment: _____

_____

_____

_____

Please list all medications you are currently taking (including supplements): _____

_____

_____

_____

DURING THE PAST FOUR WEEKS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

Nearly Daily	Sometimes	Not Really	
_____	_____	_____	Trouble remembering things
_____	_____	_____	Spells of sudden fear that did not make sense
_____	_____	_____	Trouble doing your job or school work
_____	_____	_____	Thoughts of dying
_____	_____	_____	Someone thinks you drink too much
_____	_____	_____	Being in too many arguments
_____	_____	_____	Avoiding things/places most people do not avoid
_____	_____	_____	Being in trouble
_____	_____	_____	Feeling keyed up or on edge
_____	_____	_____	Having peculiar thoughts
_____	_____	_____	Difficulties with sexual matters
_____	_____	_____	Increased stresses in your life
_____	_____	_____	Worry
_____	_____	_____	Feelings of guilt
_____	_____	_____	Not liking self
_____	_____	_____	Sad Mood
_____	_____	_____	Tearful
_____	_____	_____	Irritability easily annoyed
_____	_____	_____	Poor Concentration
_____	_____	_____	Sleep problems
_____	_____	_____	Change in appetite/not eating/throwing up after eating
_____	_____	_____	Low energy/feeling tired
_____	_____	_____	Headache/pains
_____	_____	_____	Shortness of breath, chest pains
_____	_____	_____	Dizziness, numbness, trembling
_____	_____	_____	Pains
_____	_____	_____	Self-injury behaviors
_____	_____	_____	Domestic violence

LEGAL INFORMATION

Have you ever been arrested? Yes/No If yes, at what age was your first arrest? _____
Please list all arrests below:
Where? When? Reason? Sentence?

_____

_____

_____

Do you have any legal charges pending? Yes/No
If yes, explain _____
Are you currently on probation? Yes/No
If yes, explain _____

_____ _____
Signature of Consumer Date