COMPASS COUNSELING WAUSAU, LLC
ADULT PERSONAL HISTORY

IMPORTANT

Failure to answer all questions may result in the delay of appointment scheduling. If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
NOTE: The information you provide is confidential and protected by law.

Name _____ Age _____ DOB_____
Address _____ City _____ State _____ Zip _____
Cellphone number _____ Home number _____
What are you hoping to gain in the end from this experience? _____

_____

EDUCATION:

	Name of School	Last Grade Completed	Year of Graduation	Degree
High School				
Voc/ Tech				
College				
Graduate				

EMPLOYMENT:

Employer	Start/ End Date	Job Title	Full or Part Time	Reason for leaving

How many jobs have you worked in the past 3 years? _____
Are you presently receiving SSI or Workman Compensation or Disability? ___ No ___ Yes, since: _____
Financial Status: ___ Stable: ___ Unstable: _____

MILITARY:
Have you served in the Military? _____ Yes _____ No Which branch: _____
Dates of Service: _____ Discharge Date: _____
Combat Experience: _____
Disciplinary Problems: _____

MENTAL HEALTH HISTORY:
Have you ever been in counseling in the past? ____ No ____ Yes

Clinician/ Therapist Name	Dates Seen	Reason for visits
1.		
2.		
3.		

Have you ever been hospitalized for psychiatric reasons? ___ No ___ Yes
If yes, please explain: _____

_____
Have you ever thought about committing suicide? ___ No ___ Yes. If yes, when? _____
Have you ever attempted to commit suicide? ___ No ___ Yes. If yes, when? _____

Describe your strengths: _____

_____

What things present the greatest difficulty for you: _____

_____

What are you hoping to gain in the end from this experience? _____

_____

What concerns bring you here? (Check those that apply to you in the past 4 weeks)

___ Aggressive behaviors	___ Procrastinates	___ Gets teased or bullied
___ Irritable or on edge	___ Moody	___ Argues that you are always right
___ Argues with others at home/ work	___ Depressed	___ Negative outlook on life
___ Difficulty paying attention	___ Very happy without cause	___ Recently experienced death of a loved one
___ Easily distracted	___ Does not seem to have fun	
___ Difficulty staying on task	___ Has extreme fears or phobias	___ Recently lost or changed jobs
___ Doesn't finish tasks	___ Has threatened to hurt self	___ Recently moved from home
___ Poor concentration/ focus	___ Has talked about killing self	___ Lies or misleads others
___ Poor judgement/ decision making	___ Has engaged in self- harm behavior	___ Steals
___ Impulsive	___ Has attempted suicide	___ Others think you drink too much
___ Hyperactive/ difficulty sitting still	___ Has difficulty falling asleep	___ Others think you use drugs too much
___ Often fidgets	___ Has difficulty staying asleep	___ Overreacts towards others
___ Needs directions repeated	___ Has nightmares or night terrors	___ Swears at people, things, situations
___ Anxious	___ Appetite/ weight change	___ Disrespectful to others
___ Worries or ruminates	___ Eating issues (over/ under/ purges)	___ Sexually acting out
___ Tearful/ cries easily	___ Shy around strangers	___ Skips work
___ Sensitive to what others say	___ Low self-image/ self esteem	___ Upset by family conflict
___ Socially awkward or anxious	___ Does not think any one likes you	___ Doesn't get along with others
___ Hair twirling/ pulling	___ Has excessive amounts of energy	___ Often takes too many risks
___ Panic Attack(s)	___ Poor hygiene	___ Memory difficulties
___ Avoids certain activities or places	___ Doesn't adjust easily to change	___ Does not have friends
___ Engages in repetitive behavior	___ Works too much/ too hard	___ Perfectionist

Feelings often experienced:

___ Bored	___ Regretful	___ Panicky
___ Annoyed	___ Sad	___ Restless
___ Guilty	___ Helpless	___ Hopeless
___ Unhappy	___ Energetic	___ Envy
___ Hopeful	___ Anxious	___ Relaxed
___ Lonely	___ Worthless	___ Confused
___ Hurt		___ Other: _____

MEDICAL HISTORY:

Name of Physician: _____
Last seen by physician and reason: _____
Known allergies: _____

Have you had any surgeries, hospital stays or serious illnesses? ___ No ___ Yes, please explain: _____

_____

Please list currently prescribed medications:

Medication	Dose	Frequency	Prescribing Physician
1.			
2.			
3.			
4.			

SIGNIFICANT TRAUMAS: (Include age at time of incident, nature of trauma and any legal details)

___ Injured in an accident: _____
___ Physical abuse (____ Victim ___ Perpetrator): _____
___ Sexual abuse (____ Victim ___ Perpetrator): _____
___ Emotional abuse (____ Victim ___ Perpetrator):_____

___ Neglect: _____
___ Been a victim of a crime such as assault, robbery/ burglary, stalking, sex trafficking, etc.
___ Removed from home _____ Foster Care ____ Residential Treatment
___ Head injuries or loss of consciousness. If yes, how many times: _____ Last time occurred: _____
___ Seizures. If yes, frequency: _____ Length of time they last: _____ Occurring for how long: _____
___ Pregnancy & Delivery complications. If yes, explain: _____
___ Alcohol or drug use during pregnancy. If yes, explain: _____

Mark an 'X' in all appropriate boxes.	Immediate Family					Maternal Family					Paternal Family				
	Bio- Mother	Bio- Father	Step- Parent	Brother	Sister	Grandmother	Grandfather	Step-G.Parent	Uncles	Aunts	Grandmother	Grandfather	Step- G.Parent	Uncles	Aunts
Attention Difficulties															
Learning Difficulties															
School Problems															
Behavior Problems															
Depression															
Anxiety															
PTSD															
Drug/ Alcohol Abuse															
Legal Issues															
Hallucinations/ Delusions															
Bipolar															
Eating Disorder															
Epilepsy															
Mental Retardation															
Dementia, Alzheimer's															
Traumatic Brain Injury															
Autism, Asperger's															
Heart or Lung Problems															
Speech/ Language Problem															
Genetic Disorder															
Cancer															
Diabetes															
Suicide/ Suicide Attempt															
Early Death															

FAMILY INFORMATION:

Current relationship: ___ Single ___ Married ___ Domestic Partnership ___ Separated ___Divorced ___ Widowed
Describe past significant relationships and their length: _____
_____
Full name of current spouse/ significant other: _____
Spouse/ significant other's age: _____ Spouse/ significant other's date of birth: _____/_____/_____

Spouse/ significant employer: _____ Job title: _____
Are there any problems in your relationship with your spouse/ significant other? ____ Yes ___ No
If yes, please explain: _____
What kinds of activities do you do just with your spouse/ significant other? _____
_____
Do you feel safe in your current relationship? ____ Yes ___ No If no, please explain: _____
_____

Names of Children	Living in the Home		Date of Birth	Biological or Stepchild	Quality of Relationship		
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor
	Yes	No			Good	Fair	Poor

Others living in household or of importance to you:	Date of Birth	Relationship to You	Quality of Relationship		
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor
			Good	Fair	Poor

LEGAL:
Have you ever been arrested: ___ No ___ Yes
If yes, please explain: _____
_____
Have you ever had a restraining order or no contact order against you? ___ No ___ Yes
If yes, please explain: _____
_____
Do you have any legal charges pending? ___ No ___Yes
If yes, please explain: _____
_____
Are you currently on probation? ___ No ___ Yes
If yes, please explain: _____
_____

AODA Information:

Check if ever used	Name of Chemical (Circle the applicable substance)	How much	How Often	Durations	Method	Age of First Use	Age/ Date of Last Use
	Beer, Wine, Liquor						
	Marijuana/ Hashish						
	Amphetamines, Speed, uppers, Ritalin, Dexedrine,						

	Meth, Crank, Ephedrine						
	Cocaine, Crack, Rock						
	Inhalants, (glue, aerosols, Glade, etc) LSD, PCP						
	Mushrooms, Peyote						
	Heroin						
	Opium, Morphine, Codeine						
	Methadone						
	Pain Killers (Darvon, Midol)						
	Non- barbiturates: Restoril, Unis, sleeping pills						
	Barbiturates: Amytal, Luminol, Seconal, Nemputal, downers						
	Antianxiety Agents: Valium, Librium, Ativan						
	Antipsychotic Agents: Mellaril, Risperidol						
	Antidepressants:						
	Designer drugs: Cat, Special K, Ecstasy						
	Tobacco, chew						
	Vaping, juuling						
	Other:						

Have you ever experienced blackouts or memory loss? ___ No ___Yes
If yes, please explain: _____
_____

Do you feel alcohol or drugs cause problems for you? ___No ___Yes
If yes, please explain: _____
_____

Does your family, friends or employer ever object to your drinking or drug use? ___ No ___Yes
If yes, please explain: _____
_____

Have you ever attempted to cut down or stop drinking or using drugs for a period of time? ___ No ___ Yes
If yes, please explain: _____
_____

Do you have any sexually transmitted or communicable disease? ___No ___ Yes
If yes, please explain: _____
_____

Client Signature: _____ Date: _____