SOLID GROUND COUNSELING

Plymouth and South Lyon locations

PERSONAL HISTORY INFORMATION (ADULT)

Welcome to Solid Ground Counseling! Date:_______________

The purpose of this form is to get a better understanding of your background and presenting issues. Please note that this information is confidential and, within all legal limits, will not be shared with others.

Name: ___________________________________ Social Security Number:___________________________

Address:__________________________________ Age: _____ Date of Birth:________________

City/State:________________________________ Gender:_____

Zip Code:____________ Email:_____________________@__________________

Home Phone:______________________________ Cell Phone: ______________________________________

Work Phone: ______________________________ May we leave a message at these #'s? ______________

Driver's License No.:_______________________ Occupation:_____________________________________

Place of Employment: ____

How were you referred to Solid Ground Counseling? ____

EMERGENCY CONTACT:

Name:____________________________________ Relationship to client:_____________________________

Contact Number: __________________________ Alternative Number:________________________________

Address (Street, City, State, Zip): ____

Do you have a personal representative, counselor, guardian, or representative payee? _____________________

If yes, please indicate the type of relationship and their contact information below:

Circle all that apply: Personal Representative Conservator Guardian

Name: ___________________________________ Phone Number:___________________________

Address (Street, City, State, Zip): ____

EDUCATIONAL HISTORY (CLIENT):

Highest level of education completed: Jr. High Elementary High School College Graduate School

Are you presently a student? If yes, where?____

Describe your experience / attitudes related to your highest level of education completed:____________________

____

PERSONAL CHECKLIST& SELF-DESCRIPTIVE INFORMATION:

Please check which of the following you experienced ***during childhood***:

Night terrors_______	Unusual punishment_______	Never felt good_______
Left alone a lot_______	Felt or were abused_______	Felt distant from others_______
Frequently ignored_______	Had a special pet_______	Learned things late_______
Mostly happy_______	Felt compared to others_______	Learned things early_______
Mostly unhappy_______	Didn't fit it with others_______	Frequent bed wetting_______

Please check ALL of the following that ***presently*** apply to you:

Always tired_______	Stomach problems_______	Crying spells_______
Lack of energy_______	Fast heartbeat_______	Excess alcohol use_______
Full of energy_______	Trouble sleeping_______	Excess medicine use_______
Always worried_______	Diarrhea_______	Feeling tense_______
Very restless_______	Headaches_______	Feelings of panic_______
Quick tempered_______	Shaking hands_______	Unable to relax_______
Depressed_______	Muscle twitching_______	Lacking confidence_______
Angry_______	Constipation_______	Nightmares_______
Feeling inferior_______	Cold hands/feet_______	Impatient_______
Shy with people_______	Fainting spells_______	Inability to make friends_______
Fearful_______	Dizziness_______	Inability to make decisions_______
Easily excited_______	Nausea/vomiting_______	Unable to pray_______
Feeling guilty_______	Problems with kids_______	Anxious inside_______
Financial problems_______	Problems with parents_______	Fighting/quarreling_______
Can't hold a job_______	Marital/Partner problems_______	Loss of meaning_______
Difficulties at work_______	Unable to forgive_______	Difficulties with the law_______
Difficulties in school_______	Feeling grouchy_______	Confused about religion_______
Weight loss_______	Feeling lonely_______	Feelings easily hurt_______
Poor Appetite_______	Suicidal thoughts_______	Poor physical health_______
Weight gain_______	Not enjoying things_______	Sexual problems_______
Untruthfulness_______	Unresolved grief_______	Homosexual issues_______
Frequent sweating_______	Unable to have fun_______	Loss of sexual interest_______

Issues for which you are seeking assistance:____

____

____

____

Are there precipitating events contributing to these issues? If so, what is the history of these issues?___________

____

____

What are your perceived strengths and abilities?____

____

____

What is your desired outcome for therapy?____

____

____

____

SOCIAL HISTORY

Family Information – (Include name, age, and describe closeness of relationship)

Mother:____

Father:____

Siblings:____

Spouse:____

Children:____

Step Parents:____

Step Children:____

Describe your family of origin (e.g., emotional dynamics, relationships, and patterns of dysfunction):

____

____

____

What were your families' strengths and resources?____

____

____

____

Describe how you relate to people (e.g., easily, shy, leader, follower):______________________________

____

____

With whom do you socialize and why?____

____

Do you isolate yourself from others? Yes____ No_____

Do you currently use self-injury to cope with problems? Yes____ No_____

Have you self-injured in the past to cope with problems? Yes____ No_____

Are you currently experiencing suicidal ideation? Yes____ No_____

Have you experienced suicidal ideation in the past? Yes____ No_____

SPIRITUAL BACKGROUND

Do you ascribe to a specific religion? If so, which one?____

Were you affiliated with a church as a child / adolescent? Yes____ No_____

If yes, provide name of church:____

Are you affiliated with a church currently? Yes____ No_____

If yes, provide name and city of current church:____

CULTURAL / ETHNIC INFORMATION

What cultural or ethnic group do you identify with?____

Do you closely identify with this group?____

What strengths have you acquired from this identity?____

____

LEGAL HISTORY

Is your reason for seeking counseling at Solid Ground required by a court, the police, or a probation/parole officer?

Yes____ No_____

If yes, please explain:____

____

____

Aside from traffic violations, have you encountered problems with the law in the past? Yes____ No_____

If yes, please explain:____

____

____

HABITS AND SUBSTANCE USE

Which of the following substances have you or do you presently use?

TYPE	AMOUNT	FREQUENCY	1st YEAR OF USE
Alcohol			
Marijuana			
Cocaine			
Hallucinogens			
Amphetamines			
Pain Medications			
Sleeping Pills			
Tranquilizers			
Narcotics			
Smoking Cigarettes			
Other -			
Other -			

How often do you become intoxicated or high at the present time?

Never_________ 1-3 x per month_______ 2-3 x per week________ Daily__________

Do you or a member of your family have a problem, now or in the past, with substance abuse? If yes, please explain:

____

____

____

Indicate if you have ever had experience with: overdose, withdrawal, or adverse drug or alcohol reactions:_______

____

____

Substances used recently, especially within the last 48 hours:_____________________________

____

MEDICAL HISTORY

Name of Physician:________________________________ Phone #:___________________________

Address:____

Please list current medications / dosage / frequency:_____________________________________

____

____

If prescribing physician is different from your primary care, please indicate their name and contact number:

____

Date of most recent physical exam:____

Were there any abnormal results? If yes, explain:________________________________

____

Are you experiencing any abnormal physical symptoms? If yes, explain:_________________

____

Are you currently receiving medical treatment? If yes, explain:______________________

____

Do you, or any family members, have any chronic conditions (e.g., diabetes, anemia, cancer, asthma, heart disease, high blood pressure)? If yes, explain:___________________________________

____

____

Do you have any allergies? If yes, explain:_____________________________________

____

Have you ever had any serious accidents or injuries? If yes, explain:__________________

____

Has any family member suffered from mental illness or severe depression?_______________

____

Do you have any physical disabilities or limitations? If yes, explain:___________________

____

Please list any prior treatment for emotional and/or behavioral difficulties including outpatient and inpatient treatment and approximate dates:

____

____

____

______________________________ ____________________
Client (or Guardian) Signature Date

______________________________ ____________________
Therapist's Signature Date