VALERIE L. SCHWIEBERT, Ph.D.
Wake Counseling & Consulting PLLC
1140 Holly Springs Road, Suite 207, Holly Springs, NC 27540
(919) 584-4869

PERSONAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ AGE: _____ DATE OF BIRTH: _____ TODAYS DATE: _____
SOCIAL SECURITY NUMBER: _____ PLACE OF BIRTH: _____
GENDER: ❑Male ❑ Female HEIGHT: _____ WEIGHT: _____
RACE: ❑African American ❑ Native American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Other: _____
MARITAL STATUS: ❑Single ❑Engaged ❑Married ❑Remarried ❑Separated ❑Divorced ❑Widowed ❑Living w/ partner

Please describe the problem: _____
_____
How severe are these problems? ❑Mild ❑Moderate ❑Severe ❑Extreme ❑Unable to function
How long have you had these problems? _____ Are they: ❑on-going or do they ❑come and go?

MEDICAL HISTORY: Please list any current medical problems: _____
_____
From whom or where do you get medical care? Name_____ Phone: _____
Dates & Types of recent Surgeries or Hospitalizations: _____
_____
Seizures: ❑Yes ❑No Allergies: _____
Have you ever experienced a severe accident or injury of any kind? ❑Yes ❑No When? _____
What type of accident? _____ Where was your injury? _____
How long were you hospitalized? _____ Did you lose consciousness? ❑Yes ❑No How Long? _____
How did this accident or injury affect your life/functioning? _____
Please describe any others you might have had. _____
_____

Please List All Medications Currently Prescribed for You (List additional on back):

Name of Medication	Dosage	When Started	Name of Doctor	Is It Helping?

CURRENT LIVING ARRANGEMENTS: (Names, ages, and relationship, of those living with you): _____
_____
Name of current partner: _____ Age: _____
Are you experiencing problems in this relationship? (Please describe briefly): _____
_____ Length of relationship: _____ # of Children: _____
Please list previous marriages: (Name and Year): _____ Length of marriage: _____ # of children: _____
Name & Year _____ Length of marriage: _____ # of Children: _____

CHILDREN'S NAMES AND AGES (List additional on back):

Name	***Age***	***Gender***	***Relationship (bio., step)***	***Custody?***	***Living at home?***

OCCUPATIONAL HISTORY: *What is your current work status?* ❑ *Employed full-time/part-time* ❑ *Retired* ❑ *student*
What is your current occupation? _____ *How long at this location?* _____
Do you feel your symptoms are affecting your ability to work? ❑ *Yes* ❑ *No* *In what way?* _____

Are you currently on disability? ❑ *Yes* ❑ *No* *What type of disability?* _____
Who signed your release from work? _____ *When did you begin your disability?* _____

MENTAL HEALTH HISTORY: Please check the symptoms that seem to best describe you now.

Depression
- ❑ *Sad/tearful*
- ❑ *Irritability*
- ❑ *Fatigue*
- ❑ *Worthlessness*
- ❑ *Withdrawal*
- ❑ *Hopelessness*
- ❑ *Insomnia*
- ❑ *Difficulty concentrating*
- ❑ *Memory loss*
- ❑ *Difficulty making decisions*

Anxiety
- ❑ *Worry*
- ❑ *Muscle Tension*
- ❑ *Sweating/nausea*
- ❑ *Feeling of choking*
- ❑ *Chest pain or tension*
- ❑ *Dizziness*
- ❑ *Hot/cold flashes*
- ❑ *Apprehension*
- ❑ *Tingling*
- ❑ *Numbness*

Mania
- ❑ *Excessively talkative*
- ❑ *Grandiosity*
- ❑ *Racing thoughts*
- ❑ *Decreased need for sleep*
- ❑ *Theatrical or flamboyant*
- ❑ *Risk taking behaviors*
- ❑ *Pleasure seeking*
- ❑ *Indiscretions*
- ❑ *Poor decision making*
- ❑ *Unrestrained spending*

Fears/Phobias
- ❑ *Abandonment*
- ❑ *Being alone*
- ❑ *Blood/death*
- ❑ *Crowds/strangers*
- ❑ *Leaving home*
- ❑ *People Staring*
- ❑ *Elevators*
- ❑ *Enclosed spaces*
- ❑ *Heights*
- ❑ *Failure*

Trauma
- ❑ *Traumatic event*
- ❑ *Flashbacks/nightmares*
- ❑ *Intrusive thoughts*
- ❑ *Intrusive memories/images*
- ❑ *Difficulty sleeping*
- ❑ *Sense of doom*
- ❑ *Hypervigilance*
- ❑ *Startle easily*
- ❑ *Reactive to triggers*

Obsessions
- ❑ *Recurrent/persistent thoughts*
- ❑ *Thoughts dominate time*
- ❑ *Thoughts interfere with normal routine*
- ❑ *Thoughts can=t be turned off*
- ❑ *Attempts to neutralize thoughts are not always successful*
- ❑ *Thoughts feel excessive and unreasonable*

Compulsions
- ❑ *Feel driven to perform behaviors to reduce distress or tension*
- ❑ *Perfectionism*
- ❑ *Checking/Counting*
- ❑ *Washing/Touching*
- ❑ *Repeating certain rituals*
- ❑ *Putting things in order*
- ❑ *Making things symmetrical*
- ❑ *Repeating certain words*

Addictions
- ❑ *Difficulty limiting the pursuit or use of behavior/substance*
- ❑ *Internet/sex*
- ❑ *Gambling*
- ❑ *Television*
- ❑ *Shopping*
- ❑ *Computer*
- ❑ *Nicotine/Caffeine*

Impulse Control
- ❑ *Aggression toward people*
- ❑ *Hyperactivity*
- ❑ *Irritability/Arguing*
- ❑ *Loss of temper/raging*
- ❑ *Bullying, threatening others*
- ❑ *Stealing or lying*
- ❑ *Physical/mental cruelty*
- ❑ *Blaming others*

Cognitive Dysfunction
- ❑ *Inattention/Distractibility*
- ❑ *Delusions (False ideas)*
- ❑ *Hallucinations*
- ❑ *Paranoia/Suspiciousness*
- ❑ *Cognitive confusion*
- ❑ *Dissociations*
- ❑ *Loss of time/blank outs*
- ❑ *Poor problem solving*

Personality Issues
- ❑ *Suspiciousness*
- ❑ *Low self esteem/inferiority*
- ❑ *See others as attacking you*
- ❑ *Co-dependency/Emptiness*
- ❑ *Fearful of abandonment*
- ❑ *Difficulty making decisions*
- ❑ *Unstable/volatile relationships*
- ❑ *Mood swings/unclear goals*

Other Issues
- ❑ *Over/Under weight*
- ❑ *Binging/Purging*
- ❑ *Skipping meals*
- ❑ *Divorce/Separation*
- ❑ *Grieving/mourning*
- ❑ *Custody of Children*
- ❑ *School/Career Concern*
- ❑ *Childhood Abuse*

Have you attempted suicide or thought about it? ❑ *Yes* ❑ *No* ❑ *Thoughts* *Dates:* _____
Have you been hospitalized for attempted suicide? ❑ *Yes* ❑ *No* *When?* _____ *Where?* _____
Have you been hospitalized for psychiatric reasons? ❑ *Yes* ❑ *No* *Dates:* _____
Have you been in treatment previously? ❑ *Yes* ❑ *No* *Dates:* _____
Name and location of previous therapists: _____

Would you like us to obtain those records? ❑ *Yes* ❑ *No* *Please provide the addresses or phone numbers:* _____

Has your previous therapy been helpful? ❑ *Yes* ❑ *No* *Why or why not, do you think?* _____
Have you had any negative experiences with previous therapists? ❑ *Yes* ❑ *No* *Please describe.* _____

SUBSTANCE ABUSE HISTORY: *Think about any and all chemicals you have used, & indicate how much you used & how often, then indicate the effects/consequences it had in your life (mental, physical, family, legal, etc.). Also, for each chemical, identify what caused you to stop. A=didn't stop B=money ran out C=by choice D=family E=treatment*

Substance Used	***Age Began***	***Last Use***	***Over the last 30 days***		***Why did you stop? When?***
			Amount/how often	***Effects/Consequences***	
Alcohol *(beer, wine, liquor)*					
Cannabis *(marijuana, hashish, THC)*					
Cocaine *(Coke, freebase, crack, speedball, etc.)*					
Prescription Meds *(downers, librium, valium, xanax, quaaludes, halcion, seconal, etc.)*					
Hallucinogens *(LSD, STP, PCP, etc.)*					
Opiates *(Opium, methadone, demerol, codeine, morphine, heroine, etc.)*					
Stimulants *(amphetamines, methamphetamine, speed, crystal, crank, Ritalin, etc.)*					
Inhalants:					
Caffeine:					
Nicotine:					

What are, or were, your sources of money for buying the chemicals you have used? _____

_____

Did using substances ever become such a problem for you that you experienced:

- ❑ *Loss of a job*
- ❑ *Public intoxication*
- ❑ *Shakes or tremors*
- ❑ *Driving a vehicle while intoxicated*
- ❑ *Memory loss due to intoxication*
- ❑ *Family fighting due to substance use*
- ❑ *Promises to quit that are not kept*
- ❑ *Quitting for a while then beginning again*
- ❑ *Lack of interest in other activities*
- ❑ *Missed work days*
- ❑ *Drinking while at work*
- ❑ *Black outs or passing out*
- ❑ *Arrested for DUI*
- ❑ *Withdrawals or cravings*
- ❑ *Overdoses*
- ❑ *Tolerance* (could not get high no matter how much used
- ❑ *Detox episodes*
- ❑ *Buying, selling, trading, growing - illegal drugs (explain)* _____

Are you currently participating in a 12 step program? ❑ *Yes* ❑ *No* *How often do you go?* _____
Describe how you view your alcohol use. Would you say you are: ❑ *a social drinker* ❑ *heavy drinker* ❑ *an alcoholic*
Describe how you view your drug use. Are you: ❑ *a recreational drug user* ❑ *have a problem?* ❑ *have an addiction?*

FAMILY HISTORY OF SUBSTANCE ABUSE AND MENTAL HEALTH: *Please check all that apply and indicate the family member affected.*

❑ *Subst. Abuse* _____ ❑ *Alcohol Abuse* _____ ❑ *Depression* _____
❑ *Suicide* _____ ❑ *Anxiety* _____ ❑ *Bi-polar Disorder* _____
❑ *Psychosis* _____ ❑ *Dementia* _____ ❑ *Abusive* _____

How much do you think your parents' problems contributed to your problems? ❑ None ❑ Some ❑ Great Deal ❑ all of it
Do you currently have a relationship with your parents and/or family of origin? ❑ *Yes* ❑ *No* ❑ *Varies*
How would you describe your family? happy/unhappy close/distant nurturing/abusive involved/neglectful
Describe yourself as a teenager: ❑ *out-going* ❑ *reserved* ❑ *respectful* ❑ *disobedient* ❑ *cooperative*
❑ *aggressive* ❑ *depressed* ❑ *isolated* ❑ *suicidal* ❑ *fearful* ❑ *bullied* ❑ *happy* ❑ *angry* ❑ *active*

FAMILY HISTORY CONTINUED . . . .

Are your parents: *(MOTHER)* ❑ *Living* ❑ *Deceased* *(FATHER)* ❑ *Living* ❑ *Deceased*

If your parents are still living are they: ❑ *Married* ❑ *Separated* ❑ *Divorced* ❑ *Widowed*

Mother's education: _____ *Occupation:* _____

Please describe your relationship with your Mother: _____

_____

Father's Education: _____ *Occupation:* _____

Please describe your relationship with your Father: _____

_____

Please describe your relationships with Step Parents, if applicable: _____

_____

SIBLINGS (FULL AND STEP - please identify by F for Full and S for Step):

Name	Age	Gender	Occupation	Location	Kind of Relationship
_____	____	_____	_____	_____	❑good ❑poor ❑none
_____	____	_____	_____	_____	❑good ❑poor ❑none
_____	____	_____	_____	_____	❑good ❑poor ❑none
_____	____	_____	_____	_____	❑good ❑poor ❑none

Did you experience any of the following during your childhood?

Abandonment: By Mother ❑*Yes* ❑*No* *By Father* ❑*Yes* ❑*No*

Early death of a parent: Mother ❑*Yes* ❑*No* *Father* ❑*Yes* ❑*No*

Parental Abuse: Mental ❑*Yes* ❑*No* *Physical* ❑*Yes* ❑*No* *Sexual* ❑*Yes* ❑*No* *Verbal* ❑*Yes* ❑*No* *Emotional* ❑*Yes* ❑*No*

Who was the abuser? _____ *How long did it go on?* _____

Who was the abuser? _____ *How long did it go on?* _____

Were you exposed to: Trauma ❑*Yes* ❑*No* *Domestic Violence* ❑*Yes* ❑*No* *Public Violence* ❑*Yes* ❑*No*

Growing up did you live in homes other than your parents? ❑*Yes* ❑*No* *Who did you live with?* _____

Medical problems as a child: Developmental problems ❑*Yes* ❑*No* *Serious illness* ❑*Yes* ❑*No* *Serious injury* ❑*Yes* ❑*No*

Other problems: Achievement ❑*Yes* ❑*No* *Behavioral* ❑*Yes* ❑*No* *Discipline* ❑*Yes* ❑*No*

Check any of the following problems you might have had: ❑*Night terrors* ❑*Bedwetting* ❑*Thumb sucking* ❑*Nail biting*
❑*Aggression* ❑ *Stammering* ❑*Sleepwalking* ❑*Hyperactivity* ❑ *Distractibility* ❑ *Fire setting* ❑*Severe shyness*

ACADEMIC HISTORY:

What is the highest grade you completed? _____ *GPA?* _____ *College?* ❑*Yes* ❑*No* *Major?* _____

Did you like school? ❑*Yes* ❑*No* *Were you a good student?* ❑*Yes* ❑*No* *Did you earn a degree?* ❑*Yes* ❑*No* *Year?* _____

What was your degree in? _____

MILITARY HISTORY:

Have you been in the military? ❑*Yes* ❑*No* *What branch?* _____ *From when to when?* _____

Were you assigned to combat duty? ❑*Yes* ❑*No* *Where?* _____ *For how long?* _____

What was the nature of your duties? _____

Were you injured? ❑*Yes* ❑*No* *Please describe:* _____ *Diagnosed with PTSD?* ❑*Yes* ❑*No*

LEGAL/LAW ENFORCEMENT HISTORY:

Have you been arrested, charged, or convicted of a crime? ❑*Yes* ❑*No* *Please describe:* _____

Are you currently being represented by an attorney for a legal problem? ❑*Yes* ❑*No* *Describe* _____

Is this related in any way to your treatment? ❑*Yes* ❑*No* *How?* _____

Name of Attorney or firm: _____

Thank you for completing this questionnaire. We will review it during your first session.

Signature: _____ *Date:* _____