Professional Recovery Counseling, LLC

106 Colony Park Drive #500 Cumming, GA 30040

(770)630-6892

Personal History Form / Self-Report

Name:_____Today's Date_____

Address:_____ Date of Birth:_____/_____/_____

City, State & Zip:_____ Last four of Social Security #: xxx-xxxx-_____

Home Phone: _____Work Ph:_____ Cell Ph:_____

E-mail address: _____County of Residence:_____

Which method of contact do you prefer we use? _____

Sex: (Circle) Male Female Race:_____ Marital Status:_____

How did you hear about us? _____

Emergency Contact Information: **Can we leave a message with this person? (circle) Yes No

Name:_____ Relationship to You:_____

Address:_____

City, State & Zip:_____Telephone:_____

Background Information:

Do you have any children? (Circle) Yes No How many?_____

Place of birth: _____ Total Number of Siblings:_____

Are you in contact with any extended family members _____

Are you currently employed? (circle) Yes No If yes, where?_____

Position/Title:_____

Length of Time with This Employer:_____

Longest length of employment at one agency / company: _____

Highest Level of Education:_____

Professional licensure or certifications: _____

What religious upbringing did you have?_____ Do you still practice it now? (circle) Yes No

Medical Information: *Attach another sheet if needed.*

Are you currently taking any prescription medications, for any reason? Yes No

If yes, please list them below:

Medication & Dosage	Quantity/Frequency	For the treatment of	Name of Prescribing Physician

Other Medications / Over-The-Counter / Herbals:_____

_____

Any known Allergies: (circle) Yes No If yes, please describe:_____

_____

Mental Health History

Have you ever been in counseling before? Yes No Describe your counseling experience, including likes & dislikes:_____

_____

Have you ever been hospitalized for any mental health reasons? Yes No Please list hospital and dates:

_____

What was going on in your life at that time? _____

_____

_____

Have you ever had thoughts of harming yourself, or suicidal thoughts? Yes No

Have you ever had thoughts of harming others? Yes No

Have you ever been prescribed any medications for mental health problems? Yes No

If yes, please list them below:

Medication & Dosage	Quantity/Frequency	For the treatment of	Name of Prescribing Physician

Substance Abuse History

How often do you drink alcohol? (circle one) Daily Weekly Weekends Only 2-3 times a month

Other comments about alcohol use _____

_____

Have you ever used any other drugs, "street" drugs or prescription drugs not from a doctor? Yes No

Please list what drugs you have used in the past 10 years.

1._____2._____3._____4._____5._____

When was the last time you used each of the substances listed above? (Month/Year)

1._____2._____3._____4._____5._____

Have you ever had a DUI? Yes No How many and dates of offense? _____

Have you ever been treated for abusing drugs or alcohol? Yes No

Have you ever attended SMART Recovery, AA/ NA or any other peer support group? Yes No

Have you ever had a hangover? Yes No

Have you ever missed or been late to work because you had too much to drink the night before? Yes No

Does anyone in your family have a problem drinking or using drugs? Yes No

If so, who:_____

Symptom History

Chief Complaints - Check any of the following problems that you have experienced in the *past 6 months*:

Lack of appetite	Sexual problems	Marital problems
Excessive drinking	Appetite disturbances	Family problems
Anger management	Stomach problems	Difficulty trusting
Problem drug use	Low self-esteem	Difficulty relaxing
Nervousness	Relationship problems	Isolation
Fatigue	Difficulty concentrating	Social withdrawal
Panic attacks	Flashbacks	Guilt or Shame
Anxiety	Depression	Hopelessness
Loneliness	Bowel problems	Sadness/loss
Nightmares	Bladder control problems	Easily annoyed
Intrusive thoughts	Fears/phobia	Lose track of time
Sleep disturbance	Feelings of unreality	Confusion
Headaches	Obsessive thoughts	Chest pain
Lack of appetite	Compulsive behaviors	Pain (where?)

Other comments about symptoms:

_____

_____

_____

Expectations and Interests:

In your own words, why did you come in for counseling at this time?

What do you expect to gain from your counseling experience?

Is there anything in your life about which you feel especially proud? Explain:

What are your hobbies or things you enjoy spending your time doing?

What are your dreams or goals for your life?

Is there anything else about you that you think is important for me to know?

Couples Counseling Only (Optional for Individuals):

What do you consider to be the strength of your partnership?

Other than finances, what seems to be a reoccurring problem in your relationship?

How do you and your partner usually resolve arguments or disagreements?

Have you ***ever*** been physically, sexually or emotionally abused by your partner, ***even once***? Yes No
If yes, please explain:

Have you ***ever*** physically, sexually or emotionally abused your partner, ***even once***? Yes No
If yes, please explain.

Please describe a time when you and your partner were happiest, what worked well in the relationship?

What do you hope may change about your relationship as a result of counseling?