PERSONAL HISTORY
Biological / Psychological / Social Assessment

Assessors Name:_____	**Date of Assessment:**_____

General Information

Client Name:_____	
Maiden Name (If Applicable):_____	
Date of Birth:_____	Social Security Number:_____
Address:_____ _____	

Presenting Issues:

Emergency Contact Person:	
Emergency Contact Information Phone Number:	
Primary Physician:	
Education (Level Achieved):	
Vocational Experience (If Applicable):	
Military Experience (If Applicable):	
Religious/Spiritual Affiliation (If Applicable):	

Current Living Situation

Economic Resources: Gross Income: Number in household:
Client identified Support System Available:

Five Year Employment History

Employer Name	Dates of Employment	Reason for Leaving

Social and Family History

Currently in a Relationship?		Length of Time:	
Married?:	Number of Marriages:	Separated?:	Divorced?:

Significant Other Information:

Name: Address:	
History of Alcohol and/or Drug Problems? If so, what?	
Children:	Other Children in the Home:
Names and Ages of Children:	

Information on Family Members

Name	Relationship	Health	History of Alcohol/Drug Abuse

Medical History

Have you or any of your immediate family ever been diagnosed or treated for any of the following?

Condition	Y	N	Who	Condition	Y	N	Who
Diabetes				High Blood Pressure			
Low blood sugar				Low Blood Pressure			
Heart Problems				Epilepsy			
Gastritis				Ulcers			
Pancreatitis				Cancer			
Other							

Medication list

Medication	Route	Dosage	Prescribing Dr.	Currently taking?

Risk factors for infectious disease, including HIV, AIDS, HCV, and STI's:

TB Skin Test in Last 30 Days:	If Positive, date of last chest x-ray:
TB Risk Assessment Questions	
TB Questions:	
1) Have you had contact with someone who has infectious TB disease?	Yes / No
2) Were you born in an area of the world where TB is common (ex. Asia, Africa or Latin America)?	Yes / No
3) Do you have inadequate access to health care, or have been homeless in the past two years?	Yes / No
4) Have you lived or worked in residential facilities (for example nursing homes, correctional facilities or treatment facilities)?	Yes / No
5) Have you worked in a facility where you may have been exposed to TB (health care workers who serve high risk symptoms)?	Yes / No
If any of the above questions (TB Questions) were answered yes, the client should be evaluated for the following symptoms: 1) A cough lasting over three weeks? 2) Sputum production or blood in cough? 3) Unexplained loss of appetite or sudden weight loss? 4) Fever, chills, or night sweats for no reason? 5) Persistent shortness of breath? 6) Increase fatique? 7) Chest pain?	
Other Infectious Disease	
Have you participated in any of the following high risk behaviors (i.e. unprotected sex, multiple sex partners, sex with a prostitute, IV drug use, etc.)	
Have you tested positive for HIV/AIDS	Yes / No
Hepatitis B and/or C	Yes / No
Other sexually transmitted disease	Yes / No

Risk of Suicidal or Homicidal Behavior

History of suicidal or homicidal behavior	Yes	No	Details
Suicidal thoughts?			
Suicidal Plan?			
Attempts (last 10 years)?			

History of Abuse

History or pattern of abuse	Yes	No	Victim?	Perpetrator?	Alleged/Documented
Physical abuse					
Sexual abuse					
Emotional abuse					

Drug and Alcohol History

Previous Alcohol and Drug Treatment: Yes / No *If yes please see below*		Previous Mental Health Treatment: Yes / No *If yes please see below*
Substance Abuse Provider	Dates of Care	Outcome
Mental Health Provider	Dates of Care	Outcome

Alcohol and Drug Use History

What used?	Age of first use?	Amt used	Frequency of use	Route	Longest and Last period of abstinence	Last Use	Behavior during use	Effects on Relationship

Legal History:

Past Convictions? Yes_____ No_____					
Crime of Conviction	Date(s) of incarceration	Currently on Parole?		Supervising Officer	Attorney Involved
		Y	**N**		

Pending legal charges? Yes_____ No_____					
Charge	Court date	County	Attorney Involved	Arrest Record?	
				Yes	No

DUI arrests? Yes_____ No_____ Within last 30 days? Yes_____ No_____ Total Number of DUI arrests: _____					
Date of arrest	Convicted?		Incarcerated?		Attorney Involved
	Yes	No	Yes	No	

Information from collateral sources, when available:

Summary and Recommendations • Include modality of care recommended • Rational for treatment if needed

Date: _____ Counselor Signature: _____