PERSONAL HISTORY QUESTIONNAIRE

This information is for our records and will help us to provide the best possible services. This information is confidential.
NAME: _____ DATE: _____ SEX (circle one) **Male Female**

DATE OF BIRTH _____ AGE _____ Race_____ Handedness: **Right Left Both**

Who referred you to this office & why? _____

With whom do you live? (First names, age, relationship)_____

Marital Status (circle) **Single Married Separated Divorced Remarried Widowed**

Your spouse's name _____ Their Occupation _____Dates of previous marriage _____

Your occupation _____ Your place of work _____Time in your present job? _____

Education: Years of school _____ Highest Degree _____If you are now a student, where_____

Course of study _____ **Part-time Full-time**

Please describe in your own words the reason(s) you came to see Dr. Leslie_____

_____

Have you ever received psychological/psychiatric services before? _____
If yes, please give approximate dates, names of persons who provided the service, the reasons you sought the services, the type of services (family therapy, individual therapy, medication, assessment, hospitalization, etc.) and the degree to which these services were helpful. _____

_____

HEALTH HISTORY

The following questions apply to the person receiving psychological services. (Use back of the last page if needed.)

FAMILY PHYSICIAN: _____ FAX NUMBER: _____DATE OF LAST PHYSICAL EXAM: _____

If you are currently taking medication, please describe:

Medicine	Dose/Frequency	Reason	Medicine	Dose/Frequency	Reason
1.			2.		
3.			4.		
5.			6.		
7.			8.		

Please list any major medical conditions for which you have sought treatment in the past two years. Mark with a star (*) any conditions which are chronic or currently bothering you. _____

_____

Describe any hospitalizations or surgeries within the past three years:

DATE/PLACE	REASON	PHYSICIAN	DATE/PLACE	REASON	PHYSICIAN
1.			2.		

CIRCLE ALL WHICH CURRENTLY TROUBLE YOU:

Headaches Nausea Dizziness Fevers Chest pains Blurry vision Allergies Breathing difficulties
Head injury Stomach pains Seizures Blackouts Fainting Cramps Numb/tingling limbs
Back pain Heart problems Diarrhea High blood pressure Unusual weight gain or loss
Ulcers Sexual problems Sleep disturbances Other _____

IS THERE ANY HISTORY IN YOUR FAMILY OF (circle):

Alcoholism Drug abuse Cancer Diabetes Epilepsy Heart trouble Brain tumor Dementia Ulcers Migraines
Psychiatric hospitalizations Other _____

CIRCLE ALL WHICH YOU HAVE EXPERIENCED IN THE PAST YEAR:

Death of spouse Divorce Marital separation Jail term Death of close family member Personal injury/illness
Loss of job Marital reconciliation Retirement Change in health of family member Pregnancy Sex problems
Business readjustment Gain of new family member Change in financial state Increased arguments with spouse
Other stresses _____

Please read this checklist and the items of concern to you.

_____ Household activities	_____ Self confidence	_____ Social activities	_____ Drug abuse
_____ School grades	_____ Being assertive	_____ Friendships	_____ Alcohol abuse
_____ Work	_____ Depression	_____ Financial stresses	_____ Painful memories
_____ Boyfriend/girlfriend problems	_____ Stress	_____ Sleep disturbance	_____ Word finding difficulties
_____ Relationship with spouse	_____ Dizziness/fainting	_____ Suicidal thoughts	_____ Eating problems
_____ Relationship with children	_____ Anger/temper	_____ Sexual matters	_____ Problem-solving skills
_____ Relationship with teachers	_____ Loneliness	_____ Memory	_____ Problems with concentration
_____ Relationship with boss	_____ Headaches	_____ Fatigue	_____ Problems with coordination

Do you have any reason to believe that you will be involved in any court proceedings in the near future? Please describe:

FAMILY HISTORY Please fill out this chart with information about the family who raised you.

Name Age Occupation Highest degree Marital Status Health Problems If deceased, cause of death

Father:
_____

Mother:
_____

Step parents:
_____

Brothers:
_____
_____
_____

Sisters:
_____
_____
_____

If your parents ever remarried, how old were you? _____# of marriages for Father _____Mother _____

If you have children/stepchildren: (Circle children who live with you)

Name Age Occupation Highest degree Marital Status Health Problems If deceased, cause of death

1._____
2. ._____
3. ._____
4. ._____