the Samaritan Center
Healing - Hope - Growth

CONFIDENTIAL

INDIVIDUAL HISTORY

The information requested below is to help us understand you and your situation and to enable us to help you. Please fill out this form as completely as you feel comfortable doing. This information cannot be released without the written permission of the person whose name appears on the line immediately.

YOUR NAME:_____ DATE_____

Family History

Father: Name:_____ Age:_____ Occupation:_____

Describe him as he was during your childhood:_____

_____

_____

_____

Describe him as he is/was during you adulthood:_____

_____

_____

_____

Mother: Name:_____ Age:_____ Occupation:_____

Describe her as she was during your childhood:_____

_____

_____

_____

Describe her as she is/was during you adulthood:_____

_____

_____

_____

Did other persons raise you? _____Yes _____No If yes, who?_____

Describe:_____

_____

Please circle the best-fitting choice:

Were you able to confide in your mother?		Yes	No	
Were you able to confide in your father?		Yes	No	
Home was:	Very Happy	Happy	Unhappy	Very Unhappy
In comparison with your siblings, were you disciplined?	Much More	More	Same	Less
Were your parents:	Very Strict	Strict	Not Strict	Inconsistent
As a parent, was your mother:	Excellent	Good	Poor	Very Poor
As a parent, was your father:	Excellent	Good	Poor	Very Poor
Were you closer to:	Mother	Father	Equal	Neither

In what way was discipline handled in your home and by whom?_____

_____

Were your parents divorced or separated? _____Yes _____No If yes, how old were you?_____

If your parents were divorced, how long had they been married? _____

Who began the process?_____With which parent did you live?_____

What were the circumstances?_____

Did this parent remarry? _____Yes _____No If yes, how old were you?_____

Did the other parent remarry? _____Yes _____No If yes, how old were you?_____

List brothers, sisters **and yourself** in birth order:
(use back of page, if needed)

Name	Gender	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If the sibling is deceased, at the time of his/her death, what was:

His/Her Age	Your Age	Cause of death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For members of your family: You feel closest to:_____You feel least close to:_____

Which person (family member or otherwise) has had the greatest influence on your life?_____

Why?_____

Have you lost someone close through death? _____Yes _____No

If yes: Who	Your Age	Cause of Death	Your Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Life History Data

When you were born, were there any complications? _____Yes _____No

If yes, explain:_____

Are you adopted? _____Yes _____No If yes, in what year?_____

Where?_____

Your age at the time?_____ Who adopted you?_____

What else do you know about this?_____

_____

Describe your earliest memory:_____

_____

Check any of the following childhood experiences which apply to you:

___Nail Biting	___Stuttering	___Sleepwalking	___Daydreaming	___Learning Problems
___Shyness	___Night Terrors	___Overweight	___Thumb sucking	___Imaginary Playmates
___Tics	___Slow Talking	___Bowel Problems	___Crying Spells	___Fear of Playmates
___Soiling	___Bedwetting	___Repeated Vomiting	___Temper Tantrums	___Repeated Nightmares
___Slow Physical Development		___Excessive Fighting	___Other_____	

Please explain checked items:_____

_____

Please describe any fearful or distressing experiences you've had which have not been previously mentioned:

_____

_____

School History

Briefly describe how you felt about school:_____

How often did you change schools during: Grade School_____ Junior High_____ High School_____

Were you often truant? _____Yes _____No

Were you ever in special classes? _____Yes _____No Did you ever attend classes for:

____Remedial Learning ____Handwriting ____Remedial Math ____Coordination

____Learning Disabilities ____Speech Therapy ____Hyperactivity ____Attention Deficit Disorder

Please explain checked items:_____

_____

Did you ever have other special difficulties or problems in school? _____Yes _____No

If yes, please explain:_____

How would you rate yourself as a student?_____

How do you feel about your educational achievements?_____

Do you come with any religious/spiritual concerns? _____Yes _____No

If yes, please explain:_____

Would you like your counselor to inquire about these religious/spiritual concerns? _____Yes _____No

Relational History

Current relationship status: _____Single _____Married _____Partnered _____Dating

How do you feel about your relational status?_____

Name of Partner:_____ Length of relationship:_____

Nature of relationship:_____

If married to this partner, date relationship was formalized:_____ Length of engagement:_____

Names/ages of children of this relationship:_____

If married/partnered previously: Name of former partner:_____

Date relationship began/was formalized: _____ Dissolution date (if applicable):_____

Reason: ____Death ____Divorce ____Separated ____Split-up

Names/ages of children of this relationship:_____

If married/partnered previously: Name of former partner:_____

Date relationship began/was formalized:_____ Dissolution date (if applicable):_____

Reason: ____Death ____Divorce ____Separated ____Split up

Names/ages of children of this relationship:_____

If other children, list names and ages:_____

List other people at your current address:

Name	Age	Gender	Relationship to you
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social Information

Briefly describe yourself as a person:_____

_____

In your opinion, what do other people think of you?_____

_____

How would you like to change your social life?_____

_____

Occupational History

List a brief history of employment, beginning with your current or most recent job:

Where Employed	Type of Work	How Long	Reason For Leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of jobs in the past 10 years:_____ Were you ever fired? _____Yes _____No

What was the longest job you've held and how long did you hold it?_____

_____

Over the past 5 years, has your income: ____Increased _____Decreased _____Stayed the Same

Other supplemental income?_____Inheritance _____Alimony _____Child Support _____Second Job _____Other

Are you satisfied with your current job?_____

If applicable, does your employer know you are here?_____

Legal Information

Check any current or past legal problems: ____Driving Offenses ___Financial ____Family ___Other_____

Please explain:_____

Have you been arrested or imprisoned? _____Yes _____No

If yes, have you been charged with a misdemeanor? _____Yes _____No A felony? _____Yes_____No

Please explain:_____

Are you currently involved in or considering any pending legal action? _____Yes _____No

If yes, please explain:_____

Could this legal action involve the counselor?_____ If yes, please explain:_____

Have you ever filed bankruptcy?_____ If yes, please explain:_____

Have you ever filed a lawsuit? _____ If yes, please explain:_____

Sexual History

What were your parents' attitudes toward sex?_____

_____

Were you able to talk about sex in the home?_____

When, how, and from whom did you first learn about sex?_____

_____

_____

What was puberty like for you?_____

_____

Have you had an unusual, unpleasant, or frightening sexual experience? _____Yes _____No

If yes, please explain:_____

_____

Is your current sex life satisfactory? _____Yes _____No

Do you have any sexual concerns or questions? _____Yes _____No

If you have children, are you able to talk with them about sex? _____Yes _____No

Parenting

What are your feelings about being a parent?_____

_____

If you are a parent:

What do you feel about how you are doing as a parent?_____

_____

In what ways do you (and your partner, if any) handle discipline?_____

_____

Do you have any questions or concerns about parenting?_____

_____

Recreation

Describe you leisure activities growing up:_____

_____

Describe current leisure activities:_____

_____

Medical History

List severe or unusual diseases or illness from childhood or teenage years; give ages:_____

_____

List injuries and hospitalizations not already mentioned; give dates and treatments:_____

_____

List **all medications** you are currently taking: (use back of sheet, if needed)

Medication	Dose	Frequency	Reason For	Prescribing Physician	Start Date

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Do you have physical impairments, scars, or disfigurements which concern you? _____Yes _____No

If yes, explain:_____

Checklist of Physical Concerns

Circle "R" for Regularly, "O" for Occasionally, "S" for Seldom, and "N" for never. Please circle a letter for each item.

R	O	S	N	Colds/Flu	R	O	S	N	Skin Problems
R	O	S	N	Allergies	R	O	S	N	Indigestion/Nausea
R	O	S	N	Persistent Cough	R	O	S	N	Loss of Appetite
R	O	S	N	Sinus Congestion	R	O	S	N	Exaggeration of Appetite
R	O	S	N	Headaches	R	O	S	N	Underweight
R	O	S	N	Migraine Headaches	R	O	S	N	Overweight
R	O	S	N	Clenching of Jaw	R	O	S	N	Diarrhea
R	O	S	N	Grinding of Teeth	R	O	S	N	Colitis
R	O	S	N	Muscle Tension/Cramps	R	O	S	N	Sleeping Difficulties
R	O	S	N	Chronic Pain	R	O	S	N	Exhaustion
R	O	S	N	Heart Racing	R	O	S	N	Sexual Difficulties
R	O	S	N	Chest Pains	R	O	S	N	Nervousness
R	O	S	N	High Blood Pressure	R	O	S	N	Cold Hands/Feet
R	O	S	N	Shortness of Breath	R	O	S	N	Other_____

Your height:_____ Weight:_____ Any recent changes in weight? _____Yes _____No

If yes, explain:_____

When was your last physical check-up?_____Why?_____

Results?_____

Has a family member been in psychotherapy or been hospitalized for psychiatric reasons?_____Yes _____No

If so, please describe each:_____

_____

_____

List any hereditary diseases in your family:_____

_____

Alcohol and/or Other Chemical Use

Please complete the following by inserting the appropriate information and circling the appropriate frequency code.
Please fill out each item. 1=Daily 2=Weekly 3=Monthly 4=Occasionally 5=Seldom 6=Never

	Age First Used	Frequency During Use	Age Last Used	Do You Use Now?	If yes, Current Frequency	Current Daily Dosage or Quantity	
Tobacco	_____	1 2 3 4 5 6	_____	Y N	1 2 3 4 5 6	_____	Packs
Caffeine	_____	1 2 3 4 5 6	_____	Y N	1 2 3 4 5 6	_____	Cups
Alcohol	_____	1 2 3 4 5 6	_____	Y N	1 2 3 4 5 6	_____	Drinks
Tranquilizers	_____	1 2 3 4 5 6	_____	Y N	1 2 3 4 5 6	_____	

Sleeping Pills	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Weight Reducing Pills	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Speed	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Narcotics	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Street Drugs	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Marijuana/Hashish	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Cocaine	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Hallucinogens	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____
Other:	_____	1	2	3	4	5	6	_____	Y	N	1	2	3	4	5	6	_____

Does your use of the above item(s) interfere with home, social, work, or school life? _____Yes _____No

If yes, please explain:_____

_____

Does the use of these item(s) by anyone close to you interfere with your home, social, work, or school life? ___Yes ___No

If yes, please explain:_____

_____

Do you have "after effects" from your use of alcohol or drugs? _____Yes _____No

If yes, please explain:_____

_____

* * * * * *

Is there other information about you that would help us understand you as a person?

_____

_____

_____

_____

_____

_____

_____

_____