



SOLID GROUND COUNSELING

409 Plymouth Road, Suite 100
Plymouth, MI 48170
734-927-1201

PERSONAL HISTORY INFORMATION (ADULT)

Welcome to Solid Ground Counseling!

Date: _____

The purpose of this form is to get a better understanding of your background and presenting issues. Please note that this information is confidential and, within all legal limits, will not be shared with others.

Name: _____ Social Security No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ May we leave a message at these #'s? _____

E-mail Address: _____

Age: _____ Date of Birth: _____

Occupation: _____ Driver's License No.: _____

Place of Employment: _____

How were you referred to Solid Ground Counseling? _____

In case of emergency, who do we contact? _____

Relationship to client: _____ Contact Number: _____

Address: _____
Number Street City State Zip

Are there precipitating events contributing to these issues? What is the history of your issues?

What is your desired outcome from therapy?

What are your perceived strengths and abilities?

SOCIAL HISTORY

Family Information (Please write name and age)

Mother: _____

Father: _____

Spouse: _____

Children: _____

Step Parents: _____

Step Children: _____

Describe your family of origin (e.g., emotional dynamics, relationships, and patterns of dysfunction):

What were your families strengths and resources? _____

Describe how you relate to people (e.g., easily, shy, leader, follower):

With whom do you socialize and why? _____

Do you isolate yourself from others? Yes _____ No _____

Do you currently use self-injury to cope with problems? Yes _____ No _____

Have you self-injured in the past? Yes _____ No _____

Are you or have you been suicidal? Yes _____ No _____

RELIGIOUS INFORMATION

Religion: _____

Were you affiliated with a church as a child/ adolescent? _____

Are you affiliated with a church currently? _____

Name of Church: _____ City: _____

Would you like prayer incorporated in therapy sessions? _____

CULTURAL/ ETHNIC INFORMATION

What cultural or ethnic group do you come from? _____

Do you closely identify with this group? _____

What strengths have you acquired from this identity? _____

SUBSTANCE ABUSE INFORMATION

Which of the following substances have you or do you presently use?

Type	Amount	Frequency
Alcohol	_____	_____
Marijuana	_____	_____
Cocaine	_____	_____
Hallucinogens	_____	_____
Amphetamines	_____	_____
Pain Medications	_____	_____
Sleeping Pills	_____	_____
Tranquilizers	_____	_____
Narcotics	_____	_____
Other	_____	_____

How often do you become intoxicated or high at the present time?

Never _____ Once a Month _____ 2-3 x per week _____ Daily _____

Do you or a member of your family have a problem now or in the past with substance abuse?

If yes, please explain: _____

MEDICAL HISTORY

Name of Physician: _____ Phone # _____

Address: _____
 Number Street City State Zip

Please list current medications/ dosage/ frequency: _____

If prescribing physician is different from your primary care, please state name and contact phone:

Date of most recent physical exam: _____

Any abnormal results? _____ If yes, explain: _____

Are you experiencing any abnormal physical symptoms? _____

If yes, explain: _____

Are you currently receiving medical treatment? _____

If yes, explain: _____

Do you, or any family members, have any chronic conditions (e.g., diabetes, anemia, cancer, asthma, heart disease, high blood pressure)? _____

If yes, explain: _____

Do you have any allergies? _____

If yes, explain: _____

Have you ever had any serious accidents or injuries? _____

If yes, explain: _____

Has any family member suffered from mental illness or severe depression? _____

If yea, explain: _____

Do you have any physical disabilities or limitations? _____

If yes, explain: _____

Please list any prior treatment for emotional and/or behavioral difficulites including outpatient and inpatient treatment and approximate dates:

Client (or Guardian) Signature

Date

Therapist's Signature

Date