Touchstone
Counseling Services
1625 Bethel Road, Suite 103
Columbus, Ohio 43220

PERSONAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain current and background information important to your counseling.

NAME______________________________________ DATE____________________

What are the issues that bring you to counseling at this time?

What have you done to try to resolve these problems?

What benefits do you hope to derive from counseling? Be as specific as possible.

COPING STRATEGIES

We all cope with changes and life stress in different ways. Please check the items below which seem to best describe your ways of coping. Feel free to add to the list if necessary.

___Cry	___Write/Journal	___Talk it out	___Bottle it up	___Headache
___Eat	___Feel Guilty	___Blow my top	___Tense Muscles	___Stomachache
___Pray	___Clean House	___Blame others	___Listen to Music	___Read a book
___Walk	___Sleep	___Drink	___Meditate	___Go Shopping

___Other (specify) ______________________________________

FAMILY ISSUES

Have you or anyone else in your family had experience with adoption? ___Yes ___No If yes, who, and in what way? ______________________________________

Has any member of your family had emotional problems or mental illness? ___Yes ___No If yes, which family member(s) ______________________________________

Has any member of your family had a problem with alcohol or drugs? ___Yes ___No If yes, which family member(s) ______________________________________

What does your family think of therapy?

YOUR MEDICAL/HEALTH HISTORY

Date of your last medical check-up ________________

Prescription or over-the-counter medications you are taking now	For what condition	Prescribed by

Please note any significant medical/health care in the past two years.

Year	Illness/Injury/Accident	Treatment	Current Status

YOUR MENTAL HEALTH AND SUBSTANCE USE HISTORY

Have you ever been treated for emotional problems or mental illness? ___Yes ___No If yes, please indicate the date and check the type of treatment.

Year	Counseling	Medication	Hospitalization

Have you ever been treated for alcohol or drug abuse/dependence? ___Yes ___No If yes, please indicate the year and check the type of treatment:

Year	Inpatient	Outpatient	12-Step Program Participation
			___Yes ___No
			___Yes ___No
			___Yes ___No

Please indicate your current use of alcohol, recreational drugs (including marijuana, hashish, stimulants, tranquilizers, hallucinogens, inhalants, cocaine/crack, heroin, and casual use of pain medication), tobacco and caffeine.

CURRENT USE	Frequency	Quantity	Date of Last Use
Beer			
Wine			
Liquor			
Drug (name) ________			
Drug (name) ________			
Drug (name) ________			
Drug (name) ________			
Tobacco			
Caffeine			

Have you ever experienced legal consequences of drug or alcohol use? ___Yes ___No

Have you ever experienced workplace consequences of drug or alcohol use? ___Yes ___No

Have you ever experienced social consequences of drug or alcohol use? ___Yes ___No

YOUR CURRENT SYMPTOMS

Please check any of the following that apply to you at the present time:

___Change in appetite
___Change in sleep
___Feel depressed
___Feel confused
___Irritability
___Feelings of hopelessness
___Fatigue
___Thoughts of suicide
___Guilt feelings
___Feeling helpless
___Procrastination
___Lack of interest in usual activities
___Sense of worthlessness

___Temper outbursts
___Worry
___Feel anxious
___Heart palpitations/rapid heartbeat
___Excessive sweating
___Shortness of breath/smothering sensation
___Trembling or shaking
___Difficulty relaxing
___Numbness, tingling sensation
___Sense of unreality

___Hormonal problems (including PMS)

___Difficulty concentrating
___Feelings of boredom
___Problems completing tasks
___Problems completing homework

___Annoying thoughts that won't go away
___Chronic doubt
___Repeated checking or counting

___Fear of being embarrassed
___Fear of criticism
___Fear of public speaking
___Shyness

___Overeating
___Lazy
___Work too hard
___Feel stupid or inferior
___Feel incompetent
___Home conditions bad
___Self-harm thoughts or behaviors
___Sexual problems
___Dislike being touched
___Loneliness
___Financial problems

___Other (Please indicate any symptoms you are experiencing that are not listed above):

___ ____________________ ___ ____________________
___ ____________________ ___ ____________________
___ ____________________ ___ ____________________
___ ____________________ ___ ____________________

YOUR SUPPORT

Do you have friends? ___Yes ___No Do you engage in activities with others? ___Yes ___No

Who are the people in your life that you do or could talk with about difficulties you are experiencing?

____

Please note your favorite activities or hobbies ______________________________

What spiritual practices are important to you? (This would include private prayer/individual faith practice as well as organized services/participation)

What, if any, were the spiritual or religious practices in your family of origin?

LIFE EVENTS

Please list here the life experiences you are finding most stressful at this time:

What important things have happened to you or your family in the past year?

Are there any past events that are bothering you now? ___Yes ___No
If yes, please note them here.

Please note here any other information, concerns, or issues you feel are important to mention and please note any questions you have.