Today's date:_____ Date of Assessment:_____ Clinical ID #:_____

Personal History Questionnaire (PHQ)

Client Name:_____ Date of Birth:_____ Age:_____ Sex:_____

Name of Person Completing form:_____

Referral Source:_____

Presenting Problem(s) / Reason for Assessment:

_____

_____

When and how did the problem(s) start:

_____

_____

Please check the symptoms you are having now:

- ☐ Aches/pains
- ☐ Anxious/nervous
- ☐ Ashamed
- ☐ Blames others
- ☐ Body image concerns
- ☐ Can't enjoy myself
- ☐ Choking feeling
- ☐ Cry easily/often
- ☐ Depressed/sad
- ☐ Destroys property/fires
- ☐ Difficulty breathing
- ☐ Distressing memories
- ☐ Disturbing thoughts
- ☐ Dizziness
- ☐ Eating/appetite concerns
- ☐ Elevated mood
- ☐ Excessive worry
- ☐ Feel inferior
- ☐ Feel unworthy
- ☐ Feeling paranoid/suspicious
- ☐ Forgetful
- ☐ Frequent mood swings
- ☐ Frustration
- ☐ Guilt feelings
- ☐ Headaches
- ☐ Hear voices
- ☐ Heart racing
- ☐ Heavy feeling
- ☐ Hoarding
- ☐ Hopelessness
- ☐ Hyperactivity
- ☐ Impulsive
- ☐ Irritable/angry
- ☐ Lack of motivation
- ☐ Lies/steals
- ☐ Loneliness
- ☐ Lose temper
- ☐ Low energy/tired
- ☐ Low self-esteem
- ☐ Motor or verbal tics
- ☐ Nightmares
- ☐ Numbness/tingling
- ☐ Physical aggression/cruelty animals
- ☐ Poor concentration
- ☐ Poor memory
- ☐ Racing thoughts
- ☐ Repetitive actions
- ☐ Restless/fidgety
- ☐ See images or objects
- ☐ Self harming behaviors/urges
- ☐ Sexual issues/concerns
- ☐ Shaking
- ☐ Sleep problems
- ☐ Social discomfort
- ☐ Tense feelings
- ☐ Thoughts of wanting to die
- ☐ Thoughts of wanting to hurt others
- ☐ Wound up

☐ Other symptoms:

_____

How have the problems/ symptoms affected your life?

_____

_____

Areas that have been impaired by the symptoms:

☐ Coping skills	☐ Health	☐ Occupational functioning
☐ Daily living skills	☐ Housing/shelter	☐ Self protection/personal safety
☐ Economic/financial impairment	☐ Legal difficulties	☐ Sexual functioning
☐ Educational/school function	☐ Marital/family conflict or dysfunction	☐ Socialization

Other:_____

What have you already done on your own to help?

_____

_____

_____

<u>Chemical Use History (Dim 1)</u>

Have you ever used tobacco? If yes, please describe your use:

If you drink alcohol or use drugs, how old were you when you started?

What do you typically use and how much?

Has your use ever concerned you or anyone else? Any negative consequences related to your use?

Do you gamble? If yes, has your gambling ever been a concern and/ or caused problems for you?

Where have you been treated for chemical use? Or a gambling addiction **(Dim 5)**?

Please describe your family history of addictions or chemical dependency **(Assessment Component)**:

Medical History (Dim 2)

Who is your healthcare provider? When was your last physical exam?

Describe any current medical problems or physical symptoms you are having:

List any medications you are taking (Please include dosages and reason for use if known)

Please list any important medical information (illnesses, injuries, surgeries, drug side effects)

Do you have any allergies?

Have you ever been hit in the head, or suffered head or brain trauma or injury?

Mental Health History (Dim 3)

Please list previous mental health services (include therapy, psychiatry, hospitalizations, commitments, county services, etc)

Dates of service:	Where you were seen/ treated:	Focus of treatment:

List current and previous medications you have been prescribed for mental health or psychiatric reasons (Please include dosages and reason for use if known)

Have you ever had thoughts or actions of suicide or self-harm? Or harming another person?

List your strengths and vulnerabilities **(Assessment Component)**:

Triggers and warning signs for relapse **(Dim 5)**:

Social/ Relationship History (Dim 6)

Are you currently married or in a relationship? Please provide partner's name and length of relationship:

Strengths in relationship? Problems in relationship?

Any previous marriages or significant relationships?

Please complete the following information about your children or step-children: (if applicable)

Name	Sex	Age	Living with you?	Additional information

Who is supportive of you or where do you get your support **(Dim 6)**?

Coping skills **(Dim 3)**:

Current living situation **(Assessment Component)**:

Do you have any spiritual or cultural considerations you would like us to be aware of **(Assessment Component)**?

Do you have a history of maltreatment and/ or abuse **(Assessment Component)**?

What is your sexual orientation? Do you have any concerns with sexuality **(Assessment Component)**?

Education/ Work History (Dim 6)

Highest level of Education: Do you have a diploma or GED?

What is or was school like for you? Were you ever on Truancy or an Individual Education Plan (IEP)?

Where are you currently working and how long have you been there?

Please describe your employment history: Have you been in the military?

Legal History (Dim 6)

Have you ever been convicted of an offense or crime? If yes, please provide more information.

Are you currently on probation or supervised prison release? Or have you been in the past?

If yes, for what? Please provide name of Probation Officer or Supervising Agent.

Have you been ordered by court/ probation/ parole for assessment, to attend therapy or treatment?

Family History (Assessment Component)

Where were you born and where did you grow up?

By whom were you raised? What was it like growing up in your family?

Was there any violence in your family (verbal, emotional, sexual, physical)?

Please complete the following information about your parents or step-parents:

Name/ Relationship	Age	Occupation	Alive Yes/ No

If your parents were divorced, how old were you at the time? _____

Please complete the following information about your sibling, step-siblings, or half siblings:

Name	Age	Occupation	Alive Yes/ No

Please describe your current relationships with your parents and siblings:

Have any of your family members been treated for or diagnosed with a mental illness? Please explain.

Are you aware of any developmental problems or concerns from pre-birth/ childhood/ adolescence? **(Assessment Component)**

Coordination of care

Please list any other service providers that are assisting you:

_____

_____

Do you have a Guardian or Conservator? If yes, please list the name and contact information:_____

Please give any additional information that may be important or beneficial in your treatment:

_____

_____