Lisa Headrick Meyer, M.A., LPC
Licensed Professional Counselor #3659 (GA)
2450 Atlanta Highway, Suite 1701
Cumming, GA 30040
(770) 781-3793 ~ www.meyer-counseling.com

Personal History Form / Self-Report

Name:_____ Today's Date_____

First Middle Last Type of Counseling: Individual – Marriage - Unmarried Couple

Address:_____ Date of Birth:_____/_____/_____

City, State & Zip:_____ County of Residence:_____

Main Phone Number:_(_____)_____ Alternate Phone Number: (____)_____

Email:_____ Is it okay to correspond via this email address? Yes No

Sex: (Circle) Male Female Marital Status:_____ Have you been married before? Yes No

What, if any, religious upbringing did you have?_____

Do you still practice it now? (circle) Yes No

If so, what church do you attend?_____

Who may I thank for your referral? Website Find-A-Therapist/Psychology Today Friend/Other

Other:_____

Emergency Contact Information:

Name:_____ Relationship to You:_____

Address:_____ Telephone:__(____)_____

City, State & Zip:_____

Reason for today's visit:

In your own words, why did you come in for counseling today?

_____

_____

_____

_____

_____

Background Information:

Do you have any children? (Circle) Yes No How many?_____

City & State which you were Born:_____

Total Number of Siblings:_____

Are you currently employed? (circle) Yes No Retired

Position/Title:_____ Length of Time with This Employer:_____

Highest Level of Education:_____

Longest length of employment at one agency / company:_____

Medical Information:

Are you currently taking any over-the-counter medications, including herbal remedies? Yes No

If yes, please list them below:

1._____ Dosage:_____ Quantity/Frequency:_____

For the treatment of:_____ Name of Prescribing Physician:_____

2._____ Dosage:_____ Quantity/Frequency:_____

For the treatment of:_____ Name of Prescribing Physician:_____

3._____ Dosage:_____ Quantity/Frequency:_____

For the treatment of:_____ Name of Prescribing Physician:_____

Other Medications / Over-The-Counter / Herbals:

_____

Any known Allergies: (circle) Yes No If yes, please describe:

_____

Mental Health History

Have you ever been in counseling before? Yes No

Who was your counselor?_____

Have you ever been hospitalized for any mental health reasons? Yes No

What hospital and when?_____

What was going on in your life at that time?_____

_____

_____

Have you ever had thoughts of harming yourself, or suicidal thoughts? Yes No

Have you ever had thoughts of harming others? Yes No

Have you ever been prescribed any medications for mental health problems? Yes No

Please List Medications / Physician / Purpose of Medication(s):

_____

_____

Substance Abuse History

Have you ***ever*** used alcohol, ***even once***? Yes No

How often do you drink? (circle one) Daily Weekly Weekends Only 2-3 times a month Other_____

Have you ever used any other drug, such as marijuana, cocaine, speed, LSD, heroine or any other street or prescription drugs that were not prescribed to you, ***even once***? Yes No

Please list what drugs you have used in the past, ***even once***:

1._____2._____3._____4._____5._____

When was the last time you used each of the substances listed above? (Month/Year)

1._____2._____3._____4._____5._____

Have you ever had a DUI? Yes No How many?_____

Have you ever been treated for abusing drugs or alcohol? Yes No

Have you ever attended AA or NA? Yes No

Have you ever had a hangover? Yes No

Have you ever missed or been late to work because you had too much to drink the night before? Yes No

Does anyone in your family have a problem drinking or using drugs? Yes No

If so, who:_____

_____

_____

Expectations and Interests:

What do you expect to gain from your counseling experience?

Have you ever been in counseling before? Yes No Describe your likes & dislikes:

Is there anything in your life about which you feel especially proud? Explain:

What are your hobbies or things you enjoy spending your time doing?

What are your dreams or goals for your life?

Is there anything else about you that you think is important for me to know?

Couples Counseling Only (Optional for Individuals):

What do you consider to be the strength of your marriage?

_____

_____

_____

What seems to be a reoccurring problem in your relationship with your

spouse?_____

_____

_____

How do you and your spouse usually resolve arguments or disagreements?

_____

_____

_____

Have you ***ever*** been physically, sexually or emotionally abused by your spouse, ***even once***? If so, please explain.

_____

_____

_____

Please describe a time when you and your spouse were happiest / closest. Please discuss as specifically as you can recall.

_____

_____

_____

_____

_____

_____