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**Mindful Therapy & Consulting, LLC**

**PERSONAL HISTORY FORM**

Date \_\_\_\_\_ (please print legibly)

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Address City State Zip Code

(\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Home Phone Work Phone Cell Phone

Where may I leave a message for you? Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_

Email address: \_\_\_\_\_

May I use your email address to confirm or change your appointments? No \_\_\_\_\_ Yes \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Person to be contacted in case of emergency: \_\_\_\_\_

\_\_\_\_\_  
Relationship Address

(\_\_\_\_\_) (\_\_\_\_\_) (\_\_\_\_\_) \_\_\_\_\_  
Home Phone Work Phone Cell Phone

Date of Last Physical Exam: \_\_\_\_\_ Doctor: \_\_\_\_\_

How did you hear of me? \_\_\_\_\_

Briefly describe the circumstances that bring you here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever seen a therapist before? No \_\_\_ Yes \_\_\_ Dates \_\_\_\_\_

Therapist(s) \_\_\_\_\_

\_\_\_\_\_

Are you currently under the care of a psychiatrist? No \_\_\_ Yes \_\_\_ Doctor \_\_\_\_\_

\_\_\_\_\_  
Address City State Zip Code

(\_\_\_\_\_) \_\_\_\_\_  
Phone

**MEDICAL HISTORY**

Please list any surgeries or hospitalizations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been hospitalized for mental health reasons? No \_\_\_ Yes \_\_\_ Dates \_\_\_\_\_

Hospital	Reason
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Have you ever experienced any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis           | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Leukemia            |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Migraines                | <input type="checkbox"/> Asthma              |
| <input type="checkbox"/> Allergies/Hay Fever    | <input type="checkbox"/> Fibromyaglia             | <input type="checkbox"/> Heart Attack        |
| <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Kidney Disease           | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Heart Disease       |
| <input type="checkbox"/> Alzheimers             | <input type="checkbox"/> Suicide Attempts         | <input type="checkbox"/> Schizophrenia       |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Anxiety/Panic            | <input type="checkbox"/> Drug Problems       |
| <input type="checkbox"/> Obsessions/compulsions | <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Alcohol Problems    |

Please list all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? No \_\_\_ Yes \_\_\_ (list) \_\_\_\_\_

Has any blood relative ever experienced any of the following:

- Depression (please list relationship to you) \_\_\_\_\_
- Suicide \_\_\_\_\_
- Anxiety/Panic \_\_\_\_\_
- Obsessions/compulsions \_\_\_\_\_
- Alcohol Problems \_\_\_\_\_
- Drug Problems \_\_\_\_\_
- Schizophrenia \_\_\_\_\_

**PERSONAL HISTORY**

Do you regularly smoke? No \_\_\_ Yes \_\_\_ (describe) \_\_\_\_\_

Do you usually drink over 6 cups of coffee per day? No \_\_\_ Yes \_\_\_\_\_

Do you usually drink alcohol? No \_\_\_ Yes \_\_\_\_\_

Do you use street drugs? No \_\_\_ Yes \_\_\_\_\_

Do you have difficulty falling asleep? No \_\_\_ Yes \_\_\_\_\_

Do you awaken in the middle of the night? No \_\_\_ Yes \_\_\_\_\_

Do you awaken early in the morning without apparent cause? No \_\_\_ Yes \_\_\_\_\_

Have you experienced a change in appetite? No \_\_\_ Yes \_\_\_\_\_

Have you experienced any weight changes in the past year? No \_\_\_ Yes \_\_\_\_\_

**FAMILY HISTORY**

Parents	Age	Health
Mother		
Father		
Siblings (please list)		
Spouse		
Children		
Stepchildren		

**Marital History**

Date of Current Marriage: \_\_\_\_\_

Dates of Previous Marriage(s) \_\_\_\_\_

**Educational History**

Are you currently in school? No \_\_\_\_\_ Yes \_\_\_\_\_ Where? \_\_\_\_\_  
Year in school \_\_\_\_\_

If you are not currently in school, what is the highest grade level you have achieved?

GED \_\_\_\_\_ High School Graduate \_\_\_\_\_ Some College \_\_\_\_\_ College Graduate \_\_\_\_\_ Graduate Degree \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date