# PERSONAL HISTORY QUESTIONNAIRE

*The following information will be helpful for Dr. Guth to complete your evaluation. Please bring this completed form to your first visit. You will have an opportunity to explain or clarify things that may be difficult to state in writing. Please provide as much of the requested information as possible but feel free to wait until your visit to discuss any sensitive information. Use the back of these pages or additional pages as needed.*

**DATE:_____ NAME: _____ AGE: ____ Gender: M F**
**Referred by: _____**

Is English your first language? Circle Yes or No
What other languages do you speak? _____
Will you be comfortable reading and discussing this form in English? Circle Yes or No

**Please select the main reason(s) that you are meeting with Dr. Guth:**

_____ Psychological evaluation before surgery
Type of surgery:_____ Scheduled? Yes No Date:_____
_____ Coping with pain and/or disability
_____ Coping with anxiety or trauma
_____ Depression
_____ Sexual issues
_____ Weight or eating issues
_____ Legal issues
_____ Psychological testing associated with application for religious study
_____ Other (please describe) _____

**Are you currently receiving psychological services?** Y N Name of provider:_____

**Please list all physicians who are currently providing treatment to you:**

| Physician's Name: | Medical Specialty (ex. Orthopedics, Family Medicine) |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please list your current medications: (Use back of page if necessary)**

| Medication: | Dosage | Prescribed for what condition? | Prescribed by: |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please describe your current dietary/nutritional practices (i.e., low carb, high protein, vegetarian, etc) and describe a typical day of eating: _____
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks/Supplements:_____
Do you enjoy cooking? Yes No What is your daily intake of caffeine?_____
What is your daily intake of soft drinks or beverages containing sugar? _____
How much water do you drink daily? _____
How often do you engage in physical exercise?_____ What type(s) of exercise?_____
_____
Do you have a history of binge eating? Yes No Purgative behaviors? Yes No

**ILLNESS or ACCIDENT HISTORY**

**Please describe any illness or physical/emotional disability that you may currently be experiencing.**

Date that illness/injury/disability began: _____

If the injury/pain/illness is due to an accident, please describe the accident from your perspective. Start with the events just before the accident and tell what happened just afterward. (Use the back of this page if needed.)

_____
_____
_____
_____
_____
_____

**List all treatments/surgeries for the above physical or emotional illness or injury and indicate whether treatment was helpful.**

| Treatment/Surgery | Date of Treatment/Surgery | Doctor | Helpful |
|---|---|---|---|
| _____ | | | Y or N |
| _____ | | | Y or N |
| _____ | | | Y or N |

What other treatments or surgeries do you expect to have for this condition?

_____

**Changes Associated with Physical or Emotional Injury**

What was your work schedule BEFORE the illness/accident or trauma?

_____

What was your job title, who was employer, and what were your job duties at time of accident or injury?_____

_____

Has the injury affected your ability to return to work? Y N If yes, please describe:

_____

How has the injury affected your financial situation?_____

_____

How did you feel about your job before the accident, incident or trauma?

_____

How long had you been in that job before the accident? _____

How did you spend your family/recreational and social time BEFORE the illness/accident or trauma?

_____

_____

How has the accident/illness or trauma, affected your typical daily activities?

_____

_____

SINCE the accident/illness or trauma, what have your work schedule and work activities been like?

_____

SINCE the accident/illness or trauma, how do you tend to spend family/social time?

_____

_____

SINCE the accident/illness or trauma, what are your current interests/activities/hobbies?

_____

_____

**OTHER MEDICAL HISTORY** Current Height: _____ Current Weight: _____

What other medical conditions do you have? List all other surgeries you have had:

_____ _____

_____ _____

_____ _____

Do you have any tattoos? Y N If yes, indicate number____

Do you have any body piercings Y N If yes, indicate number____

For females only: Age at first menses: _____ Age at first pregnancy: ____ Number of pregnancies:_____

**NEUROLOGICAL**

Have you ever had a seizure?..... Y N

Have you ever suffered a head injury, concussion or loss of consciousness?..... Y N

Are you currently experiencing problems with memory changes or confusion?..... Y N

**Early Development:** Are you aware of having had any medical problems in utero or infancy? .... Y N

To your knowledge, did you experience any delays in early motor, speech, or cognitive development? Y N

**MENTAL HEALTH HISTORY**

Have you recently lost or gained weight? (more than 5 pounds) ……..…….Y or N

Are you having trouble falling asleep, staying asleep, or waking up for the day?..……Y or N

How many hours of sleep do you average per night? _____

Are you having any thoughts of suicide? …….……Y or N

Have you ever intentionally tried to harm yourself or take your own life? ……Y or N

Have you ever engaged in cutting or other self-injurious behavior?.....Y or N

Are you having any thoughts of harm toward others?.....Y or N

Have you ever had outpatient mental health treatment (with a counselor, etc)?…….…….Y or N

If yes, provide approximate dates and provider name_____

Was the treatment helpful?.....Y or N

Have you ever been hospitalized for psychological reasons? ……Y or N

If yes, provide approximate dates and hospital name_____

Do you experience problems with: uncontrollable worry? ……Y or N

sudden surges in anxiety or feelings of panic? ……..Y or N

social anxiety?……...Y or N

repetitive behaviors or thoughts that are difficult to control? …..Y or N

intrusive thoughts, nightmares or flashbacks? … …….……..Y or N

If you currently experience panic symptoms, how often does this occur? _____

What factors increase likelihood of panic for you?_____

What factors decrease likelihood of panic for you?_____

Have you ever been diagnosed with ADHD?.....Y or N

If so, have you had academic accommodations for attention related issues?.....Y or N

Have you ever taken medication for attention related issues? Y or N If so, was it helpful?.....Y or N

**SUBSTANCE USE**

How many alcoholic beverages do you currently drink per week? _____

Has your use of alcohol ever interfered with your health, relationships, work, school, or legal issues? Y or N

If yes, please explain: _____

Have you ever received a DWI? ……..…… Y or N

Have you ever had treatment for alcohol or substance abuse? …… Y or N

Have you ever tried marijuana or other illegal drugs? ……..…….. Y or N

List substances and dates of first and last use: _____ _____

_____

Do you smoke cigarettes? …….……Y or N

If yes, when did you start smoking? _____ How much do you smoke per day?_____

If yes, have you ever quit before? …..Y or N How did you quit? _____

Are you interested in quitting now?.....Y or N

**FINANCIAL HISTORY**

How would you describe your current financial status?

___Comfortable; able to meet expenses and accumulate savings

___Adequate; able to meet expenses but no savings

___Stressed; not able to meet expenses

Indicate sources of financial support:____ _____

Do you currently have student loan debt? ……Y or N

Do you currently have consumer debt other than housing or car loans?.....Y or N

How much money do you spend on gambling activities per month? _____

Have you ever struggled with gambling debt in the past?.....Y or N

Have you ever declared bankruptcy?.....Y or N

**FAMILY HISTORY**

Where were you born? _____ Where were you raised? _____

Who were the adults in your household when you were growing up?

__Mother and father __Grandparent(s) __Other adult(s)_____

__Mother only __Mother and other caregiver_____

__Father only __Father and other caregiver_____

Describe your parents' marital history: (include number of marriages, separations, divorces, remarriages)

_____

_____

If your parents were divorced, how did you share time/visits with each of them?_____

_____

Did any member of your household experience problems with addiction or misuse of alcohol or drugs?...Y or N

Describe your Mother or closest caregiver: Age: _____ Occupation: _____

Physical Health Status: _____

Mental Health History:_____

Addiction History:_____

Legal History:_____

Personality Characteristics: _____

How would you describe your relationship with your mother or caregiver now?_____

Describe your Father or closest caregiver: Age: _____ Occupation: _____
Physical Health Status: _____
Mental Health History:_____
Addiction History:_____
Legal History:_____
Personality Characteristics: _____
How would you describe your relationship with your father or caregiver now?_____

How many brothers do you have? _____ How many sisters do you have? _____
Ages: _____, _____, _____, _____ Ages: _____, _____, _____, _____
How would you describe your relationship with your siblings now?_____

Complete: I am the _____ child out of ____ children in my family.

Describe the rules, routines, and responsibilities that you experienced in your household growing up:

How was conflict handled in your household?
___open, respectful discussion of feelings
___physical violence or threats of physical violence
___conflicts tended to be avoided and not addressed
___conflicts tended to be handled in open manner with compromise
In your opinion, were your financial and material needs met adequately when you were growing up?...Y or N
In your opinion, were your emotional needs met adequately when you were growing up?.....Y or N
In your opinion, have you ever experienced: physical abuse? ……..……Y or N
sexual abuse? ……Y or N
emotional abuse? ……..Y or N

How was religion/spirituality handled in your upbringing?
____ No Religion ____Not very important ____Somewhat important ____Very important

What is the role of religion/spirituality in your life today?
____No Religion ____Not very important ____Somewhat important ____Very important
What is your religious affiliation? _____
Are you currently considering religious vocation?.....Y or N
If so, please provide a brief list of significant influences and supports in your discernment journey:
_____
_____

**EDUCATIONAL HISTORY**
Did you experience learning difficulties in school? ……Y or N
What were your favorite subjects in school?_____ Least favorite?_____
Did you ever repeat a grade? …….. Y or N
Were you ever suspended or expelled for behavior problems? …….. Y or N

Please list all schools attended:

Preschool(s)_____

Elementary School(s)_____

Middle School(s)_____

What school/church/sports/music/art activities did you participate in during high school?

_____

_____

_____

Did you graduate from high school? ……. Y or N

If yes, what year? _____Name of High School _____ GPA_____

Please provide highest ACT score: _____ highest SAT score:_____

If no, what was the highest grade that you completed? _____ Did you earn a GED? ….Y or N

List any college degrees or certifications:

Degree_____ College_____ Year_____ GPA___

Degree_____ College_____ Year_____ GPA___

Degree_____ College_____ Year_____ GPA___

**OCCUPATIONAL HISTORY**

**Please list all full time and part-time jobs starting with the most recent. (Use back of page if needed)**

| Employer | Job Title | Years of Employment | Reason for Leaving Job |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

What are some of your hobbies and interests now?_____

**RELATIONSHIP HISTORY**

Are you currently sexually active?.....Y or N

At what age did you become sexually active? _____

Do you have children?.....Y or N

| Child's Name | Child's Age | Child's Other Parent's Name: | Child Lives where/with whom? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all marriages:

| Spouse's Name | Duration of marriage | Reason for end of marriage: | Status of Communication now? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you have grandchildren?: Y N If so, how many? _____
Do you have great-grandchildren? Y N If so, how many? _____

**LEGAL HISTORY**

Have you ever been arrested or charged with a crime? …….Y or N
If yes, please explain. _____
_____

**MILITARY HISTORY**

Have you ever served in the US Military? …… Y or N
If yes, what branch? _____ Dates of service: _____
Rank at discharge: _____ Was the discharge honorable? _____

**DRIVING HISTORY**

Do you currently have a valid driver's license?.....Y or N
Are you currently physically able to drive?.....Y or N

**THANK YOU FOR COMPLETING THIS FORM!**

*Please write down any questions or concerns that you would like to discuss with Dr. Guth.*