JASON T. CERRO LPC, INC.
Licensed Professional Counselor

3175 Gold Star Highway, Unit 104 G3. Mystic, CT 06355
Tel: 401-524-5938

# ADULT PERSONAL HISTORY

Patient's Name: ____________________________ Date of First Appointment: ________________
Date of Birth: ________________ Age: ________ Gender: Male Female transgender
Form Completed by (if someone other than patient): ________________________________
Address: ___________________________________ City: _________________ State: _____ Zip: ______
EMail: ___________________________________ Phone(H) ________________ (cell) ___________
Insurance Name: _______________________ ID# ______________________________________________
Specialist Visit Co-Pay: $_______ (amount on card) Patient's responsibility

Policy Holder Name( if other than patient) _____________________________ Phone# _______________
Policy Holder date of birth: ________________________________________________________________
Policy Holder Employer's Name: ______________________________________________________________

Patient was referred to Jason Cerro, LPC BY: _____________________________________

## PRESENTING ISSUE:

Please check any of the following that describe how you have been recently feeling:

Anxious Sad Depressed Frightened Angry Guilty Ashamed aggressive
Resentful Worthless
Tearful Irritable Confused Jealous Hopeless Helpless
Lonely Hyperactive Impulsive Ups and Downs
Low Energy Panic Other ___________________________________________

Please check any of the following that apply to current difficulties in your life:

Marital/Relationship Divorce/Separation Friendships
Issues with Parents Issues with Siblings Issues with Children
Employment/Retirement Pregnancy Health Problems
Eating/Appetite Problems Weight Loss/Gain Body Image
School/Learning Issues Difficulty Concentrating Language/Speech Grief/Death Sleeping
Difficulties Alcohol or Drugs
Sexual Orientation Sexual Intimacy Concerns Frequent Lying
Obsessions/Compulsions Witness to Violence Survivor of Abuse
Hallucinations Poor Memory Abusive to Animals
Theft/Stealing Problems with the Police Probation
Gang Involvement Frequent Running Away Sets Fires
Bed Wetting Smearing Feces Phobias
Cyber addiction Gambling Sexual Addiction
Other _______________________________________________________________________

How long have you experienced these difficulties in your life? __________________________
______________________________________________________________________________________

## FAMILY INFORMATION:

Check all of the information that applies to your biological parents:
Mother: Living Deceased married Divorced Remarried ___# of times

Father: Living Deceased married Divorced Remarried ___# of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?
____________________________________________

Patient Name: ______________________________

List the names and ages of your parents and any individuals who assumed parental roles:

| Name | Age | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Describe your relationship with your mother while growing up? ________________________
____________________________________________
Currently? ____________________________________________
____________________________________________

Describe your relationship with your father while growing up? ________________________
____________________________________________Currently?
____________________________________________
____________________________________________

List the first names and ages of your brothers and sisters, including you:

| Name | age | relationship (natural, step, half, etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Describe any family problems or concerns that occurred while growing up relating to:
Alcohol/Drug Abuse: ____________________________________________
____________________________________________
____________________________________________

Sexual/Physical/Verbal Abuse: ____________________________________________
____________________________________________
____________________________________________

## MARITAL HISTORY:

Marital status:
Single/Never Married Unmarried, Living Together – Length of time: ______
Married - Length of time: ______ Domestic Life Partner – Length of time: ______ Widowed - Length of time: ______
Separated - Length of time: ______
Divorce in process - Length of time: _____ Divorced - Length of time: ______
Total Number of Marriages: ______

Assessment of current relationship (if applicable): Good Fair Poor
Please list your children, if applicable:

| Name | age | Relationship (Biological/Step) | Lives with |
|---|---|---|---|

Patient Name: ______________________________

## SOCIAL RELATIONSHIPS:

Check how you generally get along with other people: (check all that apply)

Affectionate    Aggressive    Avoidant    Argumentative    Follower    Friendly
Leader    Outgoing
Shy    Submissive    Other: ______________________________

How would you describe your current support network? ______________________________

What is your Sexual Orientation?

Heterosexual    Homosexual    Bisexual    Other______________

Do you currently or have you by history experienced sexual problems? Yes    No

If yes, please describe: ______________________________

## CULTURAL/ETHNIC/SPIRITUAL:

To which cultural or ethnic group do you belong? ______________________________

Are you experiencing any problems due to cultural or ethnic issues? Yes    No

If yes, please describe: ______________________________

What is your Primary Language? ______________________________

How important to you are spiritual matters?

Not Important    Mildly Important Moderately important    Very Important

Would you like your spiritual/religious beliefs incorporated into therapy? Yes    No

If yes, please describe : ______________________________

## LEGAL:

Currently

Are you involved in any active legal cases? Yes    No

If yes, please describe: ______________________________

Are you presently on probation or parole? Yes    No

If yes, please describe: ______________________________

Past History

Do you have any legal history including, but not limited to DWI/DUI/etc., Criminal Involvement, Civil Involvement, and/or repetitive traffic violations? Yes    No

If you responded yes to the above, please fill in the following information.

| Charges | Date | Where (City) | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Patient Name: ______________________________

## EDUCATION:

Please fill in all that apply to you:

Years of education: ________________ Currently enrolled in school? Yes No

If yes, where and for what: ______________________________________________

High School Graduate/GED? Yes No

Vocational School? Graduated? Yes No Major: ___________

College? Graduated? Yes No Major: ________________

Graduate School? Graduated? Yes No Major: ___________

Military Experience? Yes No If Yes, please describe: ________________________

Special circumstances (e.g., learning disabilities, gifted)? ______________________

## EMPLOYMENT:

I am currently:

Employed Full Time Employed Part Time Employed Temporarily

Unemployed Retired Student Disabled Laid Off

If applicable, I am/was employed by ________________________________________

My job position is/was ________________________________________________

Describe your current work environment: ___________________________________

## LEISURE/RECREATIONAL:

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, religious activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

| Activity | How often now? | How often in the past? |
|---|---|---|
| | | |
| | | |
| | | |

## SUBSTANCE USE:

Do you use recreational drugs? Yes No If no, have you used previously? Yes No

If yes, please list: If yes, when did you stop? ________________

| Type of Drug | How Much | How Often |
|---|---|---|
| | | |
| | | |
| | | |

Do you drink alcohol? Yes No If no, did you drink previously? Yes No

If yes, please list: If yes, when did you stop? ________________

| Type of Alcohol | How Much | How Often |
|---|---|---|
| | | |
| | | |

Patient Name: ______________________________

Do you smoke cigarettes? Yes No

Do you use other forms of tobacco? Yes No   If yes, what kind? ____________________

## MEDICAL/PHYSICAL HEALTH HISTORY:

Please describe any important medical history, chronic ailments, or other health problems you currently experience or have experienced in the past.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please additionally describe important medical history about your immediate family members and relatives (including chronic physical ailments and emotional difficulties such as depression, anxiety, etc.).

______________________________________________________________________________
______________________________________________________________________________
______________________________

Have you ever been hospitalized for medical or psychiatric reasons? Yes   No

| Hospital | Month/Yr | Reason |
|---|---|---|
| | | |
| | | |
| | | |

Are you allergic to any medications or drugs? Yes   No
If yes, please describe: ______________________________________________________

Name of Primary Care Physician: ___________________________________________________
Physician's Address: ____________________________________________________________
Physician's Telephone Number: __________________________

Date of last medical evaluation: _________________________

## PRIOR TREATMENT HISTORY:

Have you received psychotherapy or psychiatric treatment in the past? Yes No
If yes, please list the following:

| Treatment Provider | dates | reason | your reaction to experience |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## RISK STATUS:

Have you had any suicidal thoughts recently? Yes No
If yes, please describe: ______________________________________________________
____________________________________________________________________________

Patient Name: ____________________________

Have you ever considered suicide in the past? Yes No
If yes, please describe with dates: ____________________________________________
____________________________________________________________________________

Have you attempted suicide recently or in the past? Yes No
If yes, please describe with dates: ____________________________________________
____________________________________________________________________________

Have you had any homicidal thoughts recently? Yes No
If yes, please describe: ______________________________________________________

Have you ever considered Homicide in the past? Yes No
If yes, please describe with dates: ______________________________________________
______________________________________________________________________________

Have you attempted homicide recently or in the past? Yes No
If yes, please describe with dates: ______________________________________________
______________________________________________________________________________

Have you experienced other thoughts or behaviors, recently or in the past, that concern you and/or potentially cause risk to you or others? Yes No
If yes, please describe with dates: ______________________________________________
______________________________________________________________________________

## TREATMENT PLANNING:

Is there any other information regarding you or your family that you would like to share with me that is not covered on this form?
____________________________________________
______________________________________________________________________________
________________________________________________________

What are your goals for psychotherapy?

1. ____________________________________________________________________________
______________________________________________________________________________
2. ____________________________________________________________________________
______________________________________________________
3. ____________________________________________________________________________
______________________________________________________

| ______________________ | __________ | ______________________ | __________ |
| --- | --- | --- | --- |
| Patient Signature | Date | Counselor Signature | Date |