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**Stillwater, OK 74074**  
**405-707-9600**

Date \_\_\_\_\_

**Personal History Information**

Client's Name \_\_\_\_\_ Referred By \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Birthdate \_\_\_\_\_  
Age \_\_\_\_\_ Occupation \_\_\_\_\_ Employed by \_\_\_\_\_  
Social Security # \_\_\_\_\_ Business Phone \_\_\_\_\_

**Family of Origin**

Were you raised by your natural parents? \_\_\_\_\_ If no, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Father:** Living \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Age at death \_\_\_\_\_  
Cause of death \_\_\_\_\_ Occupation \_\_\_\_\_

Describe your relationship/significant interaction with your Father.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mother:** Living \_\_\_\_\_ Age \_\_\_\_\_ Deceased \_\_\_\_\_ Age at death \_\_\_\_\_  
Cause of death \_\_\_\_\_ Occupation \_\_\_\_\_

Describe your relationship/significant interaction with your Mother.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are your parents still married or were they still married when the first one died? \_\_\_\_\_  
Which parent were you emotionally closer to? \_\_\_\_\_  
Were any other persons involved in providing parenting for you as you were growing up?  
Describe \_\_\_\_\_  
\_\_\_\_\_

**Siblings:** List ages and current geographic locations of your brother(s).

\_\_\_\_\_

List ages and current geographic locations of your sister(s). \_\_\_\_\_

\_\_\_\_\_

Which siblings were you closest to growing up? \_\_\_\_\_

\_\_\_\_\_

Do you believe that your family was emotionally close as you were growing up? \_\_\_\_\_

Describe: \_\_\_\_\_

Describe any past and/or present use of alcohol and/or drugs by other family members, including dependence or abuse, and any treatment of such: (in the last three generations)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any hospitalization or treatment of mental/emotional problems of family members (in the last three generations). Include depression and/or anxiety: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Cultural Background**

Race (Optional): \_\_\_\_\_ Do you speak any other languages? \_\_\_\_\_

Do you have any speaking, reading, or writing problems ? \_\_\_\_\_

Were you raised in an urban or rural setting? \_\_\_\_\_ Please describe any cultural considerations which you believe may affect your counseling. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Education and Religious History**

How far did you get in school? \_\_\_\_\_ If you did not complete high school, why?

\_\_\_\_\_  
\_\_\_\_\_

What kind of grades did you make? \_\_\_\_\_

What kind of classes did you do particularly well in? \_\_\_\_\_

What kind of classes did you have the most trouble with? \_\_\_\_\_

What kinds of extracurricular activities did you participate in? \_\_\_\_\_

What is your church affiliation? (Optional) \_\_\_\_\_

Have you had any bad experiences with church or religion? \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

Please describe any spiritual or religious information you believe to be pertinent to your counseling. \_\_\_\_\_

**Work History**

What are your work skills? \_\_\_\_\_

Are you satisfied with your current job? \_\_\_\_\_ Describe: \_\_\_\_\_

What kind of relationships do you have with your boss and/or coworkers? \_\_\_\_\_

Describe any problems at work which may be causing or contributing to emotional problems or stress currently: \_\_\_\_\_

How long have you been at your present job? \_\_\_\_\_ If unemployed, how long? \_\_\_\_\_ Do you have financial problems which are causing stress? \_\_\_\_\_ Describe

**Medical History**

Describe your current physical health. \_\_\_\_\_

List any known allergies \_\_\_\_\_

List, date, and briefly describe all surgeries, accidents, or major illnesses.

(Females) Do you have PMS or menstrual problems? \_\_\_\_\_ Describe:

Please review the following symptoms and put a "P" before the symptoms you have experienced in the past and a "C" before the symptoms you are currently experiencing.

- |                                 |                               |                               |
|---------------------------------|-------------------------------|-------------------------------|
| ___ Memory loss                 | ___ Anxiety/tension           | ___ Confusion                 |
| ___ Loss of interests           | ___ Fatigue/Weakness          | ___ Hallucinations            |
| ___ Appetite change             | ___ Weight gain/loss          | ___ Delusions                 |
| ___ Concern for physical health | ___ Temper                    | ___ Feelings of unreality     |
| ___ Mind racing                 | ___ Inability to focus        | ___ Paranoia                  |
| ___ Worry/fear                  | ___ Night mares               | ___ Extreme social withdrawal |
| ___ Difficulty getting to sleep | ___ Difficulty staying asleep | ___ Agitation                 |
| ___ Mood swings                 | ___ Sleeping too much         |                               |
| ___ Phobia _____                | ___ Sadness/depressed mood    |                               |

\_\_\_ Inability to experience joy      \_\_\_ Feelings of worthlessness      \_\_\_ Easily startled

\_\_\_ Chronic physical pain      \_\_\_ Fear of losing control      \_\_\_ Panic attacks

Have you ever attempted suicide? \_\_\_\_\_ If yes, give dates, circumstances surrounding attempt(s), and what happened. \_\_\_\_\_

Have you thought about suicide recently? \_\_\_\_\_ If yes, give dates and circumstances surrounding those thoughts. \_\_\_\_\_

List previous psychological, psychiatric, or substance abuse treatment (in-patient or out-patient). Give dates, locations and names of therapists/psychiatrists \_\_\_\_\_

Diagnosis if known: \_\_\_\_\_ Have you had any prior "bad" experiences with counseling and/or treatment? \_\_\_\_\_ Describe: \_\_\_\_\_

Are you currently on any medication? \_\_\_\_\_ List \_\_\_\_\_

List all current and past prescriptions for mood/mind altering medications. Indicate whether current or past with dates \_\_\_\_\_

Name and location of your current primary physician \_\_\_\_\_

List any medication allergies \_\_\_\_\_

**Marital History**

Current marital status \_\_\_\_\_ Number of marriages \_\_\_\_\_ List age at each marriage and length of marriage \_\_\_\_\_

Have you ever separated from your current spouse? \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ Abortion/Miscarriage(s) \_\_\_\_\_ Ages and gender of your children \_\_\_\_\_

Are your children living with you? \_\_\_\_\_ If no, describe: \_\_\_\_\_

Do your children present any major problems or concerns? \_\_\_\_\_ Describe \_\_\_\_\_

Describe your perception of the current state of your marriage \_\_\_\_\_

\_\_\_\_\_

Does your spouse drink/use drugs? \_\_\_\_\_ Do you believe your spouse to have an alcohol or drug problem? \_\_\_\_\_ Is your spouse emotionally, physically, or sexually abusive? \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

### **Alcohol and/or Drug History**

Do you drink? \_\_\_ Do you use drugs? \_\_\_\_\_ If yes, at what age did you first start using alcohol/drugs? \_\_\_\_\_ When was your last drink/drug? \_\_\_\_\_ List the drugs, including alcohol that you have used \_\_\_\_\_

\_\_\_\_\_

Which drug(s), including alcohol, are you presently using? \_\_\_\_\_

\_\_\_\_\_

How many drinks do you usually consume in a sitting? \_\_\_\_\_

How often do you drink? \_\_\_\_\_

Have you found that you need to drink/use more to achieve the same results? \_\_\_\_\_

Has the effect of the alcohol/drugs decreased while continuing to use the same amount? \_\_\_\_\_

Have you ever felt that you should cut down on your drinking? \_\_\_\_\_

Have you ever tried to cut down or control your use of alcohol/drugs? \_\_\_\_\_

When you have quit drinking have you experienced detox symptoms? \_\_\_\_\_

Have you attempted to avoid withdrawal or detox symptoms by using the same substance or another? \_\_\_\_\_

Have you taken more alcohol/drugs than you intended or used alcohol/drugs over a larger period of time than you intended? \_\_\_\_\_

Have you spent a lot of time in obtaining, using, or recovering from use of alcohol/drugs? \_\_\_\_\_

Have you given up important social, occupational, or recreational activities because of your drinking/using? \_\_\_\_\_

Have you continued to use alcohol/drugs despite knowledge of physical or psychological problems connect to it? \_\_\_\_\_

Do you believe that you have a problem with alcohol or other drugs? \_\_\_\_\_

Has any significant other person in your life been concerned about your drinking/using? \_\_\_\_\_ Who? \_\_\_\_\_

Have people annoyed you by criticizing your drinking? \_\_\_\_\_

Have you ever felt guilt or bad about your drinking? \_\_\_\_

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? \_\_\_\_

Have you ever had a "blackout"? \_\_\_\_

Have you ever been arrested for DWI/DUI or public intoxication? \_\_\_\_

When \_\_\_\_\_ What was the outcome? \_\_\_\_\_

Do you have any pending court dates? \_\_\_\_ When? \_\_\_\_\_

Have you ever been treated for alcoholism/chemical dependency? \_\_\_\_ If yes, list treatment facilities and dates of treatment: \_\_\_\_\_

How long were you able to maintain sobriety? \_\_\_\_\_ What was your reason for trying to stop drinking/using? \_\_\_\_\_

During detox, have you ever experienced the following: DTs \_\_\_\_ Seizures or convulsions \_\_\_\_\_. List any other major withdrawal symptoms you have experienced:

\_\_\_\_\_  
Are you an active member of AA? \_\_\_\_ What is your opinion of it? \_\_\_\_\_

Is your spouse involved in AA, NA, EA, Al-Anon, or any other 12 step program? \_\_\_\_\_

Are any other family members involved in AA, NA, EA, Al-Anon, or any other 12 step program? \_\_\_\_ If "recovering", do you have a sponsor? \_\_\_\_ How many meetings do you attend weekly \_\_\_\_\_

**Legal Problems**

List dates and circumstances of any recent or prior arrests \_\_\_\_\_

\_\_\_\_\_  
Are you currently on probation or parole? \_\_\_\_ List any legal problems (divorce, bankruptcy, lawsuits, etc.) which may pertain to stress in your life or may in any way pertain to your counseling: \_\_\_\_\_

**Strengths and Assets**

Make a list of strengths that you bring to counseling with you that you believe will help you attain your counseling goals. Examples: Ability to be flexible, willingness to try something new, hard worker, loving husband and kids, stable job, etc. \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

**Present Concerns**

In a few words, please tell why you are seeking counseling \_\_\_\_\_

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