

**Pittsburgh Pastoral Institute
Pastoral Therapy Program**

PERSONAL HISTORY FORM

Name _____ Date _____

Sex _____ Date of Birth _____ Social Security Number _____

Address _____ ZIP _____

Phone (Home) _____ Emergency Contact (person) _____
(Work) _____ (phone) _____

Life Status

Single _____	African American _____	Dates of Previous Marriages:
Married _____ date _____	Asian _____	sep. div. wid.
Widowed _____ date _____	Caucasian _____	1. _____
Divorced _____ date _____	Hispanic _____	2. _____
Separated _____ date _____	Native American _____	3. _____
Living Together _____ date _____	Other _____	

Persons currently living with you in your home (name, age, and relationship): _____

Immediate family members living elsewhere (name, age, and relationship): _____

Parental Family

<i>Father</i>		<i>Mother</i>
Name _____	Age _____	Name _____
		Age _____

Occupation _____	Occupation _____
If deceased, date and cause of death: _____	If deceased, date and cause of death: _____

Stepparents (name, age, relationship, occupation) _____

Siblings/Stepsiblings (name, age, relationship) _____

Educational & Vocational History

Education (highest level completed and date) _____

Additional education or vocational training since high school (dates, schools, programs, degrees, certificates, etc.) _____

Current Occupation/Employer: _____

Full time ____ Part time ____ Temporary ____ Unemployed ____ Disabled ____ Retired ____ Student ____
Homemaker ____ Other _____

Previous Occupations (last three employers): _____

Military Service (dates and branch) _____

Medical History

Have you, or any blood relatives, had any of the following? Please check all that apply.

M= mother F= father B= brother S= sister C= child O= other

		Self	M	F	B	S	C	O	Specify
Alcohol/drug abuse	_____								_____
Anemia	_____								_____
Asthma	_____								_____
Cancer	_____								_____
Diabetes	_____								_____
Epilepsy	_____								_____
Heart disease	_____								_____
Hepatitis	_____								_____
High blood pressure	_____								_____
HIV/AIDS	_____								_____
Low blood pressure	_____								_____
Psychiatric treatment	_____								_____
Significant weight change	_____								_____
Sleep disturbance	_____								_____
Stroke	_____								_____
Suicide attempts	_____								_____
Thyroid problems	_____								_____
Troublesome headaches	_____								_____
Venereal disease	_____								_____

Have you even been hospitalized for physical problems? No ____ Yes (specify) _____

Do you currently have any physical problems? No ____ Yes (specify) _____

Do you have a primary care practitioner? No ____ Yes (name, address, phone) _____

Are you currently taking any medications? No ____ Yes (type and amount) _____

Do you have any relevant allergies? No ____ Yes (specify) _____

Do you smoke? No ____ Yes (how much) _____

Alcohol / caffeine use? No ____ Yes (what / how much) _____

Legal Issues

Please note any past or present legal issues or problems (including dates and current status) _____

Therapeutic Background

Have you had previous therapy? No ____ Yes (name of therapist(s), date(s), and outcomes) _____

Have you been hospitalized for psychiatric treatment? No ____ Yes (specify hospital(s), date(s), and outcomes)

Do you have any suicidal or homicidal thoughts at the present time? No ____ Yes ____

If yes, do you have any suicidal or homicidal plans? No ____ Yes ____

If yes, do you intend to carry out your plans? No ____ Yes ____

Present Concerns

Briefly note the concerns that bring you to therapy and the results you hope to achieve _____

If applicable, note your religious denomination/affiliation and any spiritual/religious concerns you want to discuss

Signature _____ **Date** _____