

Pittsburgh Pastoral Institute
PERSONAL HISTORY FORM

Name _____ Date _____

Sex _____ Date of Birth _____ Social Security Number _____

Address _____ ZIP _____

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

Single _____
Married _____ date _____
Widowed _____ date _____
Divorced _____ date _____
Separated _____ date _____
Living Together _____ date _____

Dates of Previous Marriages:
sep. div. wid.
1. _____
2. _____
3. _____

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

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

Parent / Guardian Information

Name _____ Name _____

Age _____ 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: That would be helpful for therapy

Personal Health Concerns: _____

Family Health Concerns: _____

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

Primary Care Physician Information:

Name _____ Phone _____

Address _____

Height _____ Weight _____

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

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

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

Caffeine use? No ____ Yes (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

Any Additional Comments or Concerns:

Signature _____ Date _____