Laura Mangin McDonald, MA LPC
Christian Counseling

PERSONAL HISTORY QUESTIONNAIRE		
Client Name:	Gender: ▫ Male ▫ Female	DOB:
Parent or Guardian (if applicable):		Phone:
Marital Status: ▫ Married ▫ Single ▫ Divorced ▫ Separated ▫ Widowed		
Number of Children:		
Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ▫ Yes ▫ No If "yes" please give details:		
Have you previously received psychiatric services, professional counseling or psychotherapy: ▫ Yes ▫ No If "yes" please give details:		
Are you currently taking, or have you ever taken, prescribed psychiatric medication (antidepressants or other)? ▫ Yes ▫ No If "yes" please list medication and dates:		

HEALTH AND SOCIAL INFORMATION

How would you rate your present health? ▫ Very Good ▫ Good ▫ Average ▫ Below average ▫ Poor
Please list any persistent physical symptoms or health concerns:
Are you having any problems with your sleep habits? ▫ Yes ▫ No. If "yes" please describe:
Are you having any difficulty with appetite or eating habits? ▫ Yes ▫ No. If "yes" please describe:
Describe your exercise habits:
Have you experienced significant weight change within the past two months? ▫ Yes ▫ No. If "yes" please describe:
Do you regularly use alcohol? ▫ Yes ▫ No If "yes" please describe:
Do you use recreational drugs (e.g., marijuana)? ▫ Yes ▫ No. If "yes" please describe:
Do you now have or have you ever had suicidal thoughts? ▫ Yes ▫ No. If "yes" please describe the nature and frequency:

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In the past 12 months have you experienced any significant life changes or stressors (e.g., divorce, job loss, death of a loved one)? ▫ Yes ▫ No. If "yes" please describe:

Have you ever experienced any of the following:

Extreme depression	▫ Yes ▫ No
Wild mood swings	▫ Yes ▫ No
Rapid speech	▫ Yes ▫ No
Extreme anxiety	▫ Yes ▫ No
Panic attacks	▫ Yes ▫ No
Phobias	▫ Yes ▫ No
Sleep disturbances	▫ Yes ▫ No
Hallucinations	▫ Yes ▫ No
Unexplained loss of time	▫ Yes ▫ No
Unexplained memory lapses	▫ Yes ▫ No
Alcohol/substance abuse	▫ Yes ▫ No
Frequent body complaints	▫ Yes ▫ No
Eating disorder	▫ Yes ▫ No
Body image problems	▫ Yes ▫ No
Obsessive thoughts	▫ Yes ▫ No
Obsessive behaviors	▫ Yes ▫ No
Homicidal thoughts	▫ Yes ▫ No
Suicide attempt	▫ Yes ▫ No

Please describe your faith (however you define that term):

Do you consider yourself a Christian? ▫ Yes ▫ No

Have you had a personal salvation experience with Jesus Christ? ▫ Yes ▫ No. If "yes" please describe:

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Are you currently employed? ▫ Yes ▫ No
If "yes" are you satisfied at your current position? ▫ Yes ▫ No
Please list work-related stressors, if any:

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with any of the following issues?

Issue		Family Member
Depression	▫ Yes ▫ No	_____
Bipolar Disorder	▫ Yes ▫ No	_____
Anxiety Disorders	▫ Yes ▫ No	_____
Panic Attacks	▫ Yes ▫ No	_____
Schizophrenia	▫ Yes ▫ No	_____
Alcohol/Substance Abuse	▫ Yes ▫ No	_____
Eating Disorders	▫ Yes ▫ No	_____
Learning Disability	▫ Yes ▫ No	_____
Trauma	▫ Yes ▫ No	_____
Suicide Attempts	▫ Yes ▫ No	_____

What do you consider to be your strengths?
What do you like most about yourself?
What are your goals for therapy?

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