Family history for:(your name)_____ _ NOTE: This form is intended for each person that will be participating in counseling.
(Where were your born?/raised(city, state)?Were you raised by both parents /parents still together?, do you have siblings (how many)? Still in contact with siblings? How was your?, childhood (brief description of your childhood i.e., any memories of good times, not so good times ?) Please write your responses in spaces below.
To the best of your knowledge, did any of your family members experience problems with drugs, alcohol, mental illness? YES / NO (please explain)
Job/School (High school, college, GED, degrees/ Jobs – past and present
Relationship history(if applicable) (dating, marriages (any children), divorces, seperations,currently in a relationship?)
Medical history (Medical issues, surgeries)
Medications (past and present prescription medications)
Strengths (what do you know about yourself, i.e. how would you describe yourself)