Texas Self-Directed Care

Personal Life History Form

Before you begin planning your goals and the budget for your purchases, it is important to think about your life, including your mental and physical health, your family and friends, services you've used and their effect, and your educational and employment histories. Reviewing this information can help you and your SDC Advisor decide what you have and your strengths, along with what you need and your difficulties.

Remember, you are a WHOLE person, with strengths, ideas, and goals. This is true no matter what hard times you've had or are still having. Part of participating in our program is recognizing that while mental health problems may be hard to cope with, you can take an active role in managing your emotional and physical health to help you find and participate in meaningful activities in your community. Indeed, it is widely believed that having a goal or purpose in life is the best thing for your recovery.

In using this form to think about your life, we suggest the following steps:

1. Review the whole form before you start writing anything down. This will help you figure out if you need any other information to complete it (such as the types of services you've used in the past year). When you're ready, please complete all of the sections, and do not leave any questions blank. Use the back or extra sheets if you need more room to write.

2. You may choose to complete this form on your own, and then share it with your SDC Advisor. Or, you may wish to complete the form with your SDC Advisor or another trusted support person. Either way, you should choose a time to work on this form when you are most rested and focused. You also may choose not to complete it all in one session, but we ask that you have it finished within ***one week*** of having received it. (**FILL IN RETURN DATE HERE**: _____)

3. Keep a copy of this form for yourself. It will help you to assess your progress and to remember what has worked and not worked for you in the past.

Sometimes forms like these can seem overwhelming or frustrating. People who've received physical or mental health care often feel like they've completed hundreds of forms that aren't reviewed again. However, we encourage you to view this form differently. You can use it to better understand where you've been and your dreams/goals *before* you turn to making a plan and a budget for where you're going on your self-directed care journey.

Remember, life change is a process,
not a one-time event.

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Mental Wellness

Start by reviewing how your mental health affects your life. Sometimes people would rather avoid thinking about this. But, thinking about the problems you've had, what has helped you to cope with them or made them worse in the past, and the services you've had may reveal patterns that you wish to continue or change when working on your mental health recovery.

I've been diagnosed with the following psychiatric disability or mental illness:

How do you describe yourself when you're feeling well? (How can you or others tell when you're feeling well?)

Please list all of the symptoms you experience because of mental health problems (please list all of them, even if you don't have them all the time):

These mental health symptoms go away or are less bothersome when:

When mental health symptoms really start bothering me, I usually:

The symptoms get worse when:

Do you like the medications you are currently prescribed? YES NO UNSURE

Please explain what you like or don't like:

Do you adjust your medications on your own between doctor's appointments? SOMETIMES OFTEN RARELY NEVER

Please explain why you might adjust a medication between doctor's appointments:

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Please list the mental health or social services you've used in the past 12 months. These can be from a psychiatrist, a therapist, a case manager, a peer counselor, an employment specialist, a self-help group, or any services you've used to help you cope with problems.

NAME OF SERVICE	HOW OFTEN RECEIVED?	REASON FOR SERVICE	DID IT HELP YOU?	DO YOU NEED IT NOW?

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What is your overall goal related to improving your mental health symptoms or services as part of the SDC program?

What strengths or resources within yourself can help you reach this goal?

What barriers within yourself may make it hard for you to reach this goal?

What resources (people, places, and things) do you know about already that may help you reach this goal?

What barriers in your everyday life may stop you from reaching your goal?

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Physical Wellness

Now think about your physical health, especially as it affects your mental health.

Date of most recent complete physical examination (month and year): _____

			Year	Description
Are you aware of any current health problems?	**No**	**Yes**		
Are you now under medical care or taking medicines for a physical health problem?	**No**	**Yes**		

Do any of the following apply to you? Please consider any past history as well.

Serious illness	No	Yes	**Dental problem**	No	Yes	**Headaches**	No	Yes
Serious Injury	No	Yes	**Vision problem**	No	Yes	**Allergies**	No	Yes
Birth defects/inherited disease	No	Yes	**Stomach/bowels/gall bladder problem**	No	Yes	**Obesity/weight problem**	No	Yes
Surgery	No	Yes	**Rheumatic Fever**	No	Yes	**Jaundice, Hepatitis, Liver Disorders**	No	Yes
Skin/glands problem	No	Yes	**Appendicitis**	No	Yes	**Kidney/bladder problems**	No	Yes
Ears/eyes problem	No	Yes	**Cancer**	No	Yes	**Anemia or blood disorders**	No	Yes
Nose/sinus problem	No	Yes	**Sugar/Diabetes**	No	Yes	**Thyroid problems**	No	Yes
Teeth/tonsils problem	No	Yes	**Infection**	No	Yes	**Heart condition or high blood pressure**	No	Yes
Dentures	No	Yes	**Bed-wetting**	No	Yes	**Sexual problems**	No	Yes
Bridge	No	Yes	**Menstrual problem**	No	Yes	**Nervous system condition**	No	Yes
Chest/Lungs condition	No	Yes	**Hernia (rupture)**	No	Yes	**Artificial Limbs**	No	Yes
Heart Murmur	No	Yes	**Back/Limbs/Joints problem**	No	Yes	**Undiagnosed Condition**	No	Yes
Hearing problems	No	Yes	**Sleepwalking**	No	Yes	**Other:**	No	Yes

Do you have a specific goal related to improving your overall physical health or physical symptoms/problems as part of the SDC program?

YES NOT RIGHT NOW UNSURE

If yes, please briefly describe your goal:

If yes, please answer the following questions.

What strengths or resources within yourself can help you reach this goal?

What barriers within yourself may make it hard for you to reach this goal?

What resources (people, places, and things) do you know about already that may help you reach this goal?

What barriers in your everyday life may stop you from reaching your goal?

Substance Abuse/Dependence

For this part of the form, you will think about whether you abuse or are dependent on substances (alcohol, illegal drugs, or prescription drugs not taken as prescribed). Substance abuse/dependence can affect your mental health recovery and ability to reach your goals. Many people have issues with alcohol and/or drug use, so you aren't alone if this is a problem for you. There are services and supports that can be helpful.

Do you want to cut down on your drinking or use/abuse of drugs?

Do you find that people make comments about how much you drink or how often you use/abuse drugs?

Does your drinking or drug use/abuse interfere with the things you want to do in life?

Do you need a "kick-start" in the morning or afternoon? What about using alcohol or drugs to get to sleep?

Do you have a specific goal related to substances as part of the SDC program?

YES NOT RIGHT NOW UNSURE

If yes, please briefly describe your goal:

If yes, please answer the following questions.

What strengths or resources within yourself can help you reach this goal?

What barriers within yourself may make it hard for you to reach this goal?

What resources (people, places, and things) do you know about already that may help you reach this goal?

What barriers in your everyday life may stop you from reaching your goal?

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Circle of Support

Your circle of support is made up of people who care about you, advocate for you when you're not feeling well, stick with you, and believe that you can achieve what you want in life. It's okay if you only have 1-2 people in your circle right now. You may decide to add to your circle of support as part of your goals for this program.

Who are your current supporters? (Examples include: doctor, case manager, mother/father, sibling, friend, spouse/partner.)

Would you like to add to your circle of support as part of the SDC program?

YES NOT RIGHT NOW UNSURE

If yes, please answer the following questions.

Who might you like to add (boyfriend/girlfriend, friend, peer advocate, teacher, etc.)?

What strengths or resources within yourself can help you reach this goal?

What barriers within yourself may make it hard for you to reach this goal?

What resources (people, places, and things) do you know about already that may help you reach this goal?

What barriers in your everyday life may stop you from reaching your goal?

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Education / Training

Please list the training or education you've had.

Name of high school: _____

City _____ State _____ Attendance Dates: _____

Did you graduate or receive a certificate of completion? Yes No Year received, if yes: _____

Technical/vocational school, if any: _____

City _____ State _____ Attendance Dates: _____

Course of Study _____

Did you graduate or receive a certificate of completion? Yes No Year received, if yes: _____

College you attended, if any: _____

City _____ State _____ Attendance Dates: _____

Course of Study _____

Did you graduate or receive a certificate of completion? Yes No Year received, if yes: _____

Other training, if any: _____

City _____ State _____ Attendance Dates: _____

Course of Study _____

Did you graduate or receive a certificate of completion? Yes No Year received, if yes: _____

Do you have a specific goal related to education or training as part of the SDC program?

YES NOT RIGHT NOW UNSURE

If yes, please briefly describe your goal:

If yes, please answer the following questions.

What strengths or resources within yourself can help you reach this goal?

What barriers within yourself may make it hard for you to reach this goal?

What resources (people, places, and things) do you know about already that may help you reach this goal?

What barriers in your everyday life may stop you from reaching your goal?

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Employment/Volunteer Work

Please list the jobs or consulting positions you've had or volunteer work you've done. Use the back of this sheet, if needed.

Company name where you worked or volunteered: _____

Circle one:

Full-time Part-time Hourly

_____

City State Work Dates

Job Title/Position: _____

Description of your responsibilities and activities:

Company name where you worked or volunteered: _____

Circle one:

Full-time Part-time Hourly

_____

City State Work Dates

Job Title/Position: _____

Description of your responsibilities and activities:

Company name where you worked or volunteered: _____

Circle one:

Full-time Part-time Hourly

_____

City State Work Dates

Job Title/Position _____

Description of your responsibilities and activities:

Do you have a specific goal related to employment or volunteer work as part of the SDC program?

YES NOT RIGHT NOW UNSURE

If yes, please briefly describe your goal:

If yes, please answer the following questions.

What strengths or resources within yourself can help you reach this goal?

What barriers within yourself may make it hard for you to reach this goal?

What resources (people, places, and things) do you know about already that may help you reach this goal?

What barriers in your everyday life may stop you from reaching your goal?