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PERSONAL DATA FORM: The following information will be used to facilitate your therapy. As with other information you supply, it is protected by the rules of confidentiality. Please fill out the blanks as fully and as accurately as you can.

Date: _____

Name: _____ Maiden/Other Names: _____

DOB: _____ Social Security #: _____ Gender (circle): M F

Address: _____

Mailing address (if different from above): _____

Phone #'s: H) _____ W) _____ Pager: _____ E-mail: _____

Emergency contact: _____ Ph.#: _____ Relationship: _____

Primary care physician: _____ Phone #: _____

Do you want your doctor and me to share information? yes no

Current marital status: Single Married Remarried Separated Divorced Widowed

With whom do you live? (names & relationships) _____

Sexual orientation (optional): Heterosexual Bisexual Gay/lesbian Uncertain

Employer: _____

Current employment status: Employed full-time Employed part-time Homemaker full-time
 Sheltered employment Not in labor force (e.g., student) Unemployed (how long?: _____ months)

Occupation: _____ Highest year of education completed: _____

Do you have any learning disabilities? If yes, please describe _____

Who referred you to me? _____

What insurance coverage do you have? _____

Do you have any pending legal charges or involvement? If yes, please specify: _____

Present issues for which you seek treatment: _____

Give a brief history of your issues (from onset to present): _____

How would you like your situation to be different as a result of treatment? _____

How strongly do you want treatment? very much much moderately not much not at all

Please check any of the following that currently apply to you:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Difficulty with anger | <input type="checkbox"/> Unhappy with present job | <input type="checkbox"/> See things others don't see |
| <input type="checkbox"/> Tense | <input type="checkbox"/> Unable to make friends | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Others think there is something wrong with my mind |
| <input type="checkbox"/> Panicky | <input type="checkbox"/> Unable to have a good time | <input type="checkbox"/> Tension at home | <input type="checkbox"/> Hear voices others don't hear |
| <input type="checkbox"/> Lonely | <input type="checkbox"/> Frequently feel guilty | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Feel others are trying to control my mind |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Need others too much | <input type="checkbox"/> Inferiority feelings | <input type="checkbox"/> Feel shut down/numb |
| <input type="checkbox"/> Worry about sexual matters | <input type="checkbox"/> Unable to find a job | <input type="checkbox"/> Unable to keep a job | <input type="checkbox"/> Take risks excessively |
| | <input type="checkbox"/> Work too much | <input type="checkbox"/> Forgetful/spacy | |
| | <input type="checkbox"/> Moody | <input type="checkbox"/> Feel shame frequently | |
| | <input type="checkbox"/> Homicidal thoughts | | |

Mental Health Treatment History (List who provided, when, and for what issues)

Who/Where	Dates	Issues
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Have you had any hospitalizations for psychological problems? If yes, please describe _____

Have you ever made a suicide attempt? If yes, please elaborate when, how, and why _____

Has anyone in your family had psychological or substance abuse problems? If yes, please describe _____

Have any relatives committed suicide? If yes, when, how, and why? _____

Medical History

Please list any current medical problems _____

(For women only): Pregnant now? Yes No Unsure (If yes, due date: _____)

Please check if any of the following symptoms currently apply to you:

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drinking too much fluid | <input type="checkbox"/> Tingling in hands or feet |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Big appetite | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Deafness | |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Ringing in ears | |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Problems with sexual organs | | |

Please list all medications you currently use, both prescribed and non-prescribed:

Name of medication	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any addictions to prescribed medications? If yes, which ones _____

Have you had any hospitalizations for medical reasons? If yes, please describe _____

Please mark if you or any blood relatives have had any of the following (Mark **Y** for you and **R** for relative):

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart trouble |
| <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disease |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Other hormonal illness | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Head injury | | <input type="checkbox"/> Eye trouble |

Alcohol and Drug History

In the last year, have you ever drunk or used drugs more than you meant to? Yes No

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? Yes No

Any drug or alcohol related arrests? No Yes Ever had D.T.'s (delirium tremens)? No Yes

Any blackouts from drugs or alcohol? No Yes Ever injected drugs? No Yes

How many cigarettes, if any, do you smoke in a day? _____

How much coffee or drinks with caffeine do you drink in a day? _____

Please check which of the following substances you have used:

Substance	When began use?	Used in past year?	How often?
Alcohol	_____	_____	_____
Inhalants/Glue	_____	_____	_____
Marijuana/Hashish	_____	_____	_____
Amphetamines/Speed	_____	_____	_____
Barbituates/Downers	_____	_____	_____
Valium, Xanax, etc.	_____	_____	_____
Psychedelics/LSD,etc.	_____	_____	_____
Cocaine/Crack	_____	_____	_____
Heroin/Opiates	_____	_____	_____
Other _____	_____	_____	_____

Religious/Spiritual:

What was your religious upbringing? _____

What do you currently practice? _____

Trauma history: (Check any that apply and elaborate below)

- | | | |
|--|---|---|
| <input type="checkbox"/> Minor/major car accidents | <input type="checkbox"/> Invasive medical/dental procedures | <input type="checkbox"/> Falls |
| <input type="checkbox"/> Natural disasters | <input type="checkbox"/> Illnesses involving high fever | <input type="checkbox"/> Accidental poisoning |
| <input type="checkbox"/> Abandonment | <input type="checkbox"/> Prolonged immobilization, e.g, casting | <input type="checkbox"/> Exposure to extreme heat or cold |
| <input type="checkbox"/> Difficult birth | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Rape or assault |
| <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Parental divorce |
| <input type="checkbox"/> Loss of a loved one | <input type="checkbox"/> Catastrophic injury | <input type="checkbox"/> Other |
| <input type="checkbox"/> War trauma | <input type="checkbox"/> Witnessing domestic violence | |

Is there anything else you would like to tell me?