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Personal Information Form: Please fill this out as fully and accurately as possible to facilitate your therapy. As with other information that you supply, this is protected by the rules of confidentiality.

Date: _____

Name: _____ Maiden/other name: _____

DOB: _____ Social Security #: _____ (sometimes necessary for insurance)

Address: _____

Mailing address if different: _____

Phone: H)_____ W)_____ Cell)_____ E-mail_____

Emergency contact: _____ Phone:_____ Relationship:_____

Primary Care Physician: _____ Phone:_____ Share info? __Yes __No

Marital Status:___Single ___Married ___Cohabitating ___Remarried ___Separated ___Divorced ___Widowed

With whom do you live? (Name, age, relationship):_____

_____

_____

Sexual orientation (optional): ___Heterosexual ___Bisexual ___Gay/Lesbian ___Uncertain

Employer: _____Employment status: ___Full-time ___Part-time ___Homemaker full-time ___Student ___Unemployed (how many months? ___)

Occupation:_____ Highest year of education completed: _____

Any learning disabilities? If yes, please describe: _____

Who referred you to me? _____

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

_____

Issues for which you seek treatment: _____

_____

Brief history of issues (when started, what triggered, etc.):_____

_____

_____

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

In the past two weeks, please check to indicate how much these problems bothered you:

	Not at all	A little	Somewhat	A lot
Feeling irritated/angry/grouchy	___	___	___	___
Feeling sad or blue	___	___	___	___
Feeling hopeless about the future	___	___	___	___
Little interest or pleasure in doing things	___	___	___	___
Feeling guilty	___	___	___	___
Thinking that you are too needy	___	___	___	___
Feeling lonely	___	___	___	___
Feeling anxious/worried/on edge	___	___	___	___
Feeling panicked	___	___	___	___
Avoiding situations that make you anxious	___	___	___	___
Experiencing a lot of energy	___	___	___	___
Taking risks and starting lots of projects	___	___	___	___
Thoughts of hurting yourself or others	___	___	___	___
Feeling numb or shut down	___	___	___	___
Feeling detached from everything	___	___	___	___
Feeling helpless, discouraged	___	___	___	___
Being forgetful or spacy	___	___	___	___
Repetitive unpleasant thoughts	___	___	___	___
Urge to do a particular act repeatedly	___	___	___	___
Feeling inadequate or inferior	___	___	___	___
Hearing voices when no one is there	___	___	___	___
Believing that you or others can read minds	___	___	___	___
Difficulty at home	___	___	___	___
Difficulty socially	___	___	___	___
Difficulty at work or school	___	___	___	___
Worry about sexual matters	___	___	___	___
Feeling lost in life, not knowing who you are	___	___	___	___
Working too much	___	___	___	___

Mental Health Treatment History:

With Whom?	Dates?	Issues addressed?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any hospitalizations for mental health issues? If yes, please describe _____

_____

Have you ever attempted suicide? 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, who, when, how, why_____

_____

Spiritual/Religious background and current interest:_____

Medical History:

Please list any current medical problems:_____

_____

Please check any of the following symptoms that currently apply:

___Nightmares	___Increased/decreased appetite	___Weight gain/loss
___Hair loss	___Sleeping too much	___Difficulty falling/staying asleep
___Fatigue	___Indigestion	___Chronic pain
___Chest pain	___Headaches	___Dizziness
___Constipation	___Diarrhea	___Shortness of breath
___Heart racing/pounding	___Drinking too much fluid	___Nausea
___Urinary problems	___Tingling in hands or feet	___Ankle swelling
___Deafness	___Ringing in ears	___Menstrual problems

___Problems with sexual organs

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

_____

Please list all medications you currently use, both prescribed and over-the-counter:

Medication:	*Dosage:*	*Prescribed by:*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any addictions or allergies to medications? If yes, which ones?_____

Have you or any blood relatives had any of the following (Mark Y for You, R for Relative)?

___Cancer	___Heart trouble	___High blood pressure	___Diabetes
___Thyroid issues	___Epilepsy/seizures	___Head injury	___Autism
___ADHD	___Allergies/Asthma	___Miscarriage	___Abortion

In the past week, approximately how many drinks of alcohol did you have? ___ Maximum you had per time___

In the past week, approximately how many times did you use marijuana? ___ Maximum you had per time ___

In the past month, have you ever felt you ought to cut down on drinking or drug use? ___Yes ___No

In the past month, have you ever felt annoyed by people criticizing your drinking or drug use? ___Yes ___No

Ever had drug or alcohol related arrests? ___Yes ___No Any blackouts from drugs or alcohol? ___Yes ___No

Please list any drugs other than prescriptions that you have used in the past year _____

_____

Describe any significant history of drug use (age when started, type of drug, etc.)_____

_____

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

How many caffeinated drinks, if any, do you have in a day? _____

Trauma History: Please check if any of these have happened to you and give details on the back of this page.

___Minor/major car accident	___Invasive medical/dental work	___Major fall	___Natural disaster
___Illness involving high fever	___Accidental poisoning	___War trauma	___Difficult birth
___Abandonment	___Physical abuse	___Sexual abuse	___Emotional abuse
___Witnessing violence	___Loss of a loved one	___Parental divorce (age at the time____)	
___Major injury	___Exposure to extreme heat or cold	___Rape or assault	
___Prolonged immobilization (e.g. casting)	___Other_____		