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# PERSONAL DATA

***This is a confidential record of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by law as explained in the consent to treatment. Please fill out completely.***

**CLIENT PROFILE**

Name: ______________________________________________ Referred By:____________________________________________________

Address: __________________________________ City: _____________________________ Zip Code: ____________________________

Home Phone: ( ) ______________________ Cell Phone: ( ) ____________________ Work Phone: ( ) ___________________

May I call you at home? (Circle One) YES NO May I call you at work? (Circle One) YES NO

Person to notify in case of emergency: __________________________________ Phone Number: ______________________________

Age: ____________ Birthdate: ____________________ Social Security Number_______________________________________________

Occupation: _______________________________________ How long? ______________________________________________________

Work address: ______________________________ City: ______________________________ Zip Code: ___________________________

Previous Occupations: _______________________________________________________________________________________________

Insurance Provider: _____________________________ Group#: ___________________ Insurance ID#__________________________

**In your own words, please state the nature of your main problem:**

**How would you rate how serious this problem feels to you? (Circle One) 1 2 3 4 5**

**Mildly Upsetting Extremely Serious**

**MEDICAL HISTORY**

Name of Primary Care Physician: _____________________________________________________________________________________

Physician's Address: _______________________________________________________________________________________________

Current medications being taken:

1)_______________________ Dosage/Freq___________ Start Date___________Purpose_________________________________

2)_______________________ Dosage/Freq ___________ Start Date___________Purpose_________________________________

3)_______________________ Dosage/Freq ___________ Start Date___________Purpose_________________________________

4)_______________________ Dosage/Freq ___________ Start Date___________Purpose_________________________________

Prescribed by: ___________________________________________________________________________________________________

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Do you use recreational drugs? (Circle One) YES NO If no, have you previously used? (Circle One) YES NO

If yes, when did you stop? ________________________________

| Type of Drug | How much | How often |
| --- | --- | --- |
| ______________________________________ | ______________ | _______________________________________________ |
| ______________________________________ | ______________ | _______________________________________________ |
| ______________________________________ | ______________ | _______________________________________________ |

Do you drink alcohol? (Circle One) YES NO If no, did you previously drink? (Circle one) YES NO

If yes, please list:

| Type of Alcohol | How much | How often |
|---|---|---|
| ___________________________________ | _____________ | __________________________________________ |
| ___________________________________ | _____________ | __________________________________________ |

Do you smoke cigarettes? (Circle One) YES NO

Describe any other health problems or important medical history (i.e. trouble sleeping, back pain, digestive problems):

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: ______________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

**SCHOOL AND FAMILY HISTORY**

What was the last year of school you completed?

________________________________________________________________________________________________________

Please list any schools you are currently attending:

________________________________________________________________________________________________________

Describe your current support network (i.e. friends, relatives, work associates etc.):

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Please check all information which applies to your biological parents:

| MOTHER | | FATHER | |
|---|---|---|---|
| | ____ living | | ____ living |
| | ____ deceased | | ____ deceased |
| | ____ married | | ____ married |
| | ____ divorced | | ____ divorced |
| | ____ remarried ____# of times | | ____ remarried ____# of times |

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

________________________________________________________________________________________________________

Where do your parents live? Mother ______________________________________________________________________

Father ______________________________________________________________________

Describe your relationship with your mother while growing up: ________________________________________________

________________________________________________________________________________________________________

Currently: ______________________________________________________________________________________________

Describe your relationship with your father while growing up: ______________________________________________
______________________________________________________________________________________
Currently: ______________________________________________________________________________
______________________________________________________________________________________

List first names and ages of brothers & sisters:

| Name | Age | Relationship (natural, step, half, etc.) |
|---|---|---|
| ______________________ | _____ | ______________________________ |
| ______________________ | _____ | ______________________________ |
| ______________________ | _____ | ______________________________ |
| ______________________ | _____ | ______________________________ |

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: ______________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

Sexual/physical/emotional abuse: ______________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

**MARITAL HISTORY**

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____________ If currently living w/someone, how long? ______________

Please list your children:

| Name | Age | Relationship (biological/step) | Lives with |
|---|---|---|---|
| __________________ | ____ | _________________ | ________________________ |
| __________________ | ____ | _________________ | ________________________ |
| __________________ | ____ | _________________ | ________________________ |
| __________________ | ____ | _________________ | ________________________ |

**MENTAL STATUS**

Please check any of the following that describe how you have been feeling lately:

____sad ____anxious ____depressed ____frightened ____guilty ____angry ____ashamed ____aggressive ___resentful

____worthless ___tearful ____irritable ____confused _____extreme ups/downs _____jealous _____hopeless ____helpless

Describe any other feelings you have had:_______________________________________________________
______________________________________________________________________________________

What activities or hobbies do you participate in? ________________________________________________
______________________________________________________________________________________

Do you participate in regular exercise? (Circle One) YES NO

Describe: ______________________________________________________________________________

Describe your current working environment: ______________________________________________

______________________________________________________________________________________

Have you had any change in sleeping habits? (Circle One) YES NO

Describe: ______________________________________________________________________________

______________________________________________________________________________________

Have you had any change in eating habits? (Circle One) YES NO

Describe: ______________________________________________________________________________

______________________________________________________________________________________

Have you ever **considered suicide**? (Circle One) YES NO

If so, please give a brief description with dates: ______________________ ______________________

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: ______________________________________________

Have you **attempted suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: ______________________________________________

List or describe any current stressors or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significantly difficult getting to work or completing daily tasks, severe financial strain, recent divorce, or problems with supervisor, etc.): ______________________________________________

______________________________________________________________________________________

**THOUGHTS**: Please check any of the following that apply to you:

_____I sometimes hear voices, even though no one nearby is talking to me.

_____I sometimes feel that forces outside of me control me.

_____I sometimes feel that other people control my thoughts.

_____I sometimes have the same thought over and over and cannot control it.

_____I sometimes feel that someone is out to hurt me or do something against me.

_____I am sometimes unable to control my behavior. Please explain: ______________________________

______________________________________________________________________________________

______________________________________________________________________________________

Is there any other information regarding you or your family that you would like to share that has not been covered?

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________