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PERSONAL INFORMATION FORM

Name_____ Date _____
Tel: (cell) _____(home) _____(work)_____
Email: _____Date of Birth _____
Home Address:_____
May I contact you at work? ____ May I leave messages for you at work? ____ work?_____ home?_____ cell?_____
Marital Status: Never Married Engaged Married Separated Divorced Widowed Re-married
Referred by:_____

List members of your family and/or all others living in your home:

Name	**Sex**	**Age**	**Relationship to you**	**Occupation**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Education: _____
Occupation: _____
Emergency Contact: _____(ph)_____
Briefly describe your reason for seeking help, and what you hope to achieve in therapy:
_____
_____
Date of last examine by a physician: _____
Name of physician: _____ Phone number: _____

List any major health problems for which you currently receive treatment:
_____
_____

List all medications you are now taking and who is prescribing them:
_____
_____

Dates of previous counseling: _____
Reason: _____
Counselor: _____
Have you ever been hospitalized for a psychiatric disorder? _____
Dates: _____ Hospital: _____
Reason:_____

Please Circle Those That Apply:

Depressed mood	Elevated mood	Panic symptoms
Persistent sadness	Legal matters	Fear
Crying spells	Shortness of breath	Shyness
Inability to enjoy things	Increased appetite	Decreased appetite
Excessive weight gain	Excessive weight loss	Increased sleep
Anger	Loneliness	Trouble with friends
Nervousness	Aggression	Spiritual confusion
Decreased sleep	Irritability	Loss of motivation
Fatigue	Marriage problems	Excessive guilt
Difficulty concentrating	Feeling worthless	Financial concerns
Hopelessness	Preoccupation with death	Defeating thoughts
Self-harm	Poor memory	Suicide attempt(s)
Racing thoughts	Suicidal thoughts	Trouble with children
Increased talking	Mood swings	Increased activity
Bowel troubles	Stomach troubles	Other addictions
Compulsive dieting	Alcohol or drug use	Blackouts
Sexual difficulties	Vomiting	Obsessive thoughts
Obsessive behaviors	Hallucinations	Aches/pains
Bizarre thoughts	Racing heart	Compulsive behaviors
Impulse control	Stress	Headaches
Nightmares	Problems with parents	Problems being a parent
Trouble with decisions	Career choices	Divorce
Health concerns	Problems at work	Inferiority feelings