

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 the law as explained in our consent to treatment. Please fill out completely.

Who referred you to me for counseling services: _____

Client Name: _____ Male Female

Address City Zip Code

Home Phone (_____) Cell Phone (_____)

Work Phone (_____) E-mail _____

May we call you at home? Y N At Work? Y N

Person to notify in case of emergency _____ Phone Number (_____)

Age _____ Birthdate _____ Social Security Number _____

Occupation _____ How Long? _____ Highest Grade Completed _____

Job/Career Satisfaction (low) 1 -----5----- 10 (high)

Work Address City Zip

Previous Occupations _____

Ethnicity: Caucasian African American Hispanic Asian Other _____

NOTE: It is important for the client and therapist to determine together what part spiritual or religious issues will or will not take in therapy.

Would you like spirituality/religious issues to be a part of your therapy?

Y N Don't Know Church Affiliation (if any) _____

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

What goal(s) would you like to accomplish through counseling?

FAMILY INFORMATION

Marital status – current: Single Married Divorced Separated

Widow/er Partner Dating

If married: Age of Spouse: _____ Date of Marriage: _____

If divorced: Date of marriage to ex-spouse: _____ Date of Divorce: _____

If divorced more than once: Date of previous marriage: Date of Previous Divorce:

If separated: Date of Separation: _____

If involved with a “significant other”: His/her name His/her occupation

• If you live together: since when? How long known?

Would you describe your intimate relations as satisfactory or unsatisfactory ?

Children: _____ / _____

Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____
Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____
Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____

Are your children living with you? Yes No

Other children living with you:

Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____
Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____

Other adults living with you:

Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____
Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____

FAMILY HISTORY

Parents: Father:

Father: _____ / _____

Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____

Occupation _____

Mother: _____ / _____

Name	Age	Name	Age
_____ / _____	_____ / _____	_____ / _____	_____ / _____

Occupation _____

Did you grow up with both parents in the home? Y N

If your parents divorced, what age were you? _____

Custody Arrangement: _____

Step-Father: _____ / _____
Name Age Name Age

Occupation _____

Step-Mother: _____ / _____
Name Age Name Age

Occupation _____

Do you feel closest to your Father? Mother Step Mother Step Father
None Other _____:

Briefly describe your relationship with your Father: _____

With your Mother: _____

Siblings: Brother/s:

_____ / _____
Name Age Name Age

_____ / _____
Name Age Name Age

Sister/s:

_____ / _____
Name Age Name Age

_____ / _____
Name Age Name Age

Other: Please explain if any member of your family has ever suffered from anything
which could be described as an “emotional” or “psychological” problem: _____

Please mention any history of domestic violence, child abuse or sexual abuse in your
family: _____

Please comment on any history of alcohol abuse or illegal drug use in your family: _____

MEDICAL INFORMATION

Current Weight: _____ One Year Ago: _____ Maximum: _____ When: _____

Do you exercise regularly? Y N How?

Do you sleep well? Y N Amount (hours) _____ Easy to get to sleep? Y N

What recreation do you enjoy? _____

Primary Physician _____ City _____ Date of last physical _____

The hardest time in your development (life) was:

Preschool Grade School Jr. High High School College Now

MEDICATION HISTORY

<i>Please check all that apply to you:</i>	<i>NEVER</i>	<i>SELDOM</i>	<i>SOMETIMES</i>	<i>OFTEN</i>
Appetite Suppressants				
Pain Relievers				
Sedatives/Tranquilizers				
Sedatives/Tranquilizers				
Sleep Aids				
Stimulants				
Blood Pressure Meds				
Heart Medicine				
Vitamins				
Other (please specify) _____ _____				
<i>Other Medical Issues or Conditions:</i>	<i>NEVER</i>	<i>SELDOM</i>	<i>SOMETIMES</i>	<i>OFTEN</i>
Insomnia				
Loss of Appetite				
Back Pain				
Asthma				
Headaches				
Phobias (Fears)				
Nausea				
Allergies				
Nervousness				
Loss of temper				
Fatigue				
Depression				
Anxiety				
High blood pressure				
Constipation				
Diarrhea				
Over-eating				
Mood swings				
<i>Substance use/abuse:</i>				
Smoking: Packs per week _____				
Alcohol • Frequency (per week): _____ • How Much? _____ What do you drink? • Beer Wine Hard Licqure				
Marijuana • Frequency (per week): _____ • How Much? _____				
Other Drugs • Type: _____ • Frequency (per week): _____ • How Much? _____				

Please list all current medications: _____

Comments: _____

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y N

If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y N If YES, when? _____

If YES, method used: _____

Have you ever been hospitalized for psychiatric reasons? Y N

• If YES, when? _____ Length of hospital stay _____