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PERSONAL INFORMATION FORM

Name _____

Address _____

Email _____

Cell # _____ Do you text from this number? Yes No

Other # _____ Specify work, home, etc. _____

Male/Female _____ Age _____ Date of Birth _____

Ethnic background _____

Relationship status _____

[single, (re)married, dating, cohabitating, engaged, separated, divorced, widowed]

Children (names/ages) _____

With whom do you live? _____

Highest level of education _____

Occupation _____

Employer _____

Referred by _____

In case of an emergency, I give permission for my therapist to contact the following:

Name: _____ Phone: _____ Relationship: _____

Describe your primary concern(s) and why you decided to seek help at this time.

What are your goals, hopes and expectations regarding counseling?

Have you ever received counseling before? Yes No

If yes, with whom, when, and for what reasons? Include contact phone/address

What was the date of your last physical exam? _____

Current and significant past illnesses, health conditions _____

Current medications and reason(s) for taking _____

Name and phone number of primary physician _____

Have you ever been prescribed or taken any medication for any psychological problems? Yes No

If yes, provide the name of the medication, dosage, and dates taken _____

If yes, provide the name and phone number of prescribing doctor: _____

Have you ever been hospitalized for any mental, emotional or behavioral problems? Yes No

If yes, when, where, and for what reasons? _____

Did or does anyone in your family have a mental illness or emotional problem? Yes No

If yes, please list and describe _____

Have you experienced problems related to any of the following?

(Please mark **P** if you experienced it in the **Past** and **C** if you are **Currently** experiencing it.

Please put a * next to those that are significant to you **Now**.)

	Difficulty concentrating		Spiritual
	Relationship difficulties		Fidgety and restless
	Self-hatred		Affairs/infidelity
	Fear or panic		Loss of appetite
	Pornography		Underlying sadness
	Sleep Problems		Loss or grief
	Up and down mood cycles		Loss of interest in work or activities
	Compulsive thoughts or behaviors		Legal problems
	Difficulties in sexual function/performance		Hearing or seeing things that others do not
	Thoughts of death		Indecisiveness
	Difficulties with emotions		Feeling misunderstood or judged
	Difficulty trusting the motives of others		Intrusive thoughts or impulses
	Gender/sexual identity issues		Depression/hopelessness
	Anger, frustration or rage issues		Work problems
	Overeating/undereating &/or purging		Insecurity/poor self-image
	Alcohol/substance abuse/misuse		Distressing fantasies
	Self-harming/cutting		Addiction
	Anxiety/worry		Abortion
	Guilt or shame		Traumatic events (including abuse)
	Feelings of worthlessness		Flashbacks
	Promiscuity		Isolation

Further details about significant symptoms: _____

Have you ever had suicidal thoughts? Yes No Suicidal attempts? Yes No

If yes, please describe and give date(s): _____

Would you like spirituality to be part of the counseling process? Yes No

Is there any other information you think is important for your therapist to know? _____