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PERSONAL INFORMATION FORM

Name_____Today's Date_____
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 illnessess, 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

Have you ever had suicidal thoughts? Yes☐ No☐ Suicidal attempts? Yes☐ No☐
If yes, please describe and give date(s): _____
_____
_____

Have you ever, are you currently or do you plan to be involved in a lawsuit?: _____
_____
_____
_____

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