PERSONAL INFORMATION SHEET

The following form, which will become a part of your confidential record, will enable us to gain a more complete understanding of you and your current situation. Please answer each question as completely as you can.

Date _____

Name _____

Sex **M** **F** Age _____ Date of Birth _____

Address _____

_____Zip_____

Phone Information:

Day _____ May we leave a message? **Yes** **No**

Evening _____ May we leave a message? **Yes** **No**

Cell _____ May we leave a message? **Yes** **No**

Email Address _____

Emergency Contact:_____

EDUCATIONAL BACKGROUND Circle the highest level of education completed:

6 7 8 9 10 11 12 1 2 3 4 1 2 3 4 5

Jr. High High School College or Vocational Ed Graduate School

Current Diplomas or Degrees held: _____

EMPLOYMENT BACKGROUND: Are you currently employed?_____

Employer's Name:_____

Type of Work/Position:_____Length of Time:_____

PERSONAL INFORMATION:

Describe any physical problems you have that require medication or physical care:_____

Are you currently taking any prescription medication?_____

If yes, please list medication and reason (use back of page if necessary):

ALCOHOL AND SUBSTANCE USE:

How many alcoholic beverages in one week? _____

How many days of the week are alcoholic beverages used? _____

List all substances used in the past or present: _____

How long ago was last substance use? _____

FAMILY BACKGROUND:

Siblings (Please list in birth order and age):_____

Current Marital Status:_____

If Married: Spouse's Name:_____Age:_____

Spouse's Occupation:_____

Length of Marriage:_____

If Divorced: Number of Times:_____ Length of Marriage(s):_____

Date of and reason for divorce(s):

_____

_____

Children (Name, Age & Sex): _____

_____

Which still reside in your home?_____

Have you had any other pregnancies?_____

SPIRITUAL BACKGROUND:

Do you attend a local church?_____If yes, where?_____

How frequently?_____For how long?_____

What is your belief about God, Jesus Christ, the Bible?_____

_____

_____

How would you rate your current interest in spiritual growth?

1 2 3 4 5 6 7 8 9 10

No Interest Not Sure Very Interested

ADDITIONAL INFORMATION:

What is happening in your life that resulted in this appointment?

_____
_____
_____

When did this begin?_____

Rate the severity of this concern, with 1 being not at all severe, and 10 being very severe.

_____

What seems to make the problem worse? _____

What seems to make the problem better? _____

What have you done to try to solve this problem? _____

Have you been court ordered to discuss this problem? _____YES _____NO

Have major changes of any kind occurred in your family in recent months/years (for example: moves, finances, illness, death, divorce, prison)?

_____
_____

Please check any symptoms you are experiencing:

__Aggression	__Fatigue	__Racing thoughts
__Anger outbursts	__Fears (list below)	__Restlessness or on edge
__Alcohol abuse	__Gambling	__Sexual addiction
__Anxiety	__Hallucinations	__Sexual difficulties
__Avoidance of people	__Headaches	__Sleeping problems
__Chest pains	__Helplessness	__Stressed out
__Computer addiction	__Hopelessness	__Suicidal thoughts
__Depression	__Impulsivity	__Trembling
__Difficulty concentrating	__Indecisiveness	__Weight gain/loss
__Difficulty thinking	__Irritability	__Withdrawal
__Distractibility	__Loneliness	__Worrying
__Dizziness	__Memory problems	__Worthlessness
__Drug Abuse	__Mood swings	__Other symptoms:
__Eating disorders	__Muscle tension	_____
__Elevated mood	__Panic attacks	_____

List all previous mental health treatment and provider: _____
_____

List any mental health problems in your extended biological family: _____
_____

Please check current stressors:

__Conflict with children
__Conflict with parents
__Conflict with siblings
__Conflict with other family
__Emotional problems
__Financial problems
__Health problems
__Job loss or change
__Legal problems
__Substance abuse
__Other
__Marital conflict
__Physical problems
__Poor peer relations
__Problems at school
__Problems at work
__Recent move
__Housing problems
__Sexual problems
__Separation or divorce
__Victim of abuse

Who do you consider to be your support system?_____

What would you like to see accomplished in counseling?

_____
_____

RISK ASSESSMENT

	PAST	NOW
Have you ever had thoughts of hurting yourself?		
Have you ever had thoughts of committing suicide?		
Have you ever had a plan to commit suicide?		
Have you made threats to kill yourself?		
Have you ever made a suicide attempt?		
Have you ever purposely hurt yourself (i.e. cutting)?		
Have you ever had thoughts of harming someone?		
Have you ever made threats to harm someone?		
Have you ever attempted to harm someone?		
Have you ever been threatened with harm by someone very close to you?		

What additional information would be helpful for your therapist to know?

_____
_____
_____