

PERSONAL DATA SHEET

Name: _____ Personal email address (if any) _____

Today's Date: _____ Date of Birth: _____

Please fill out the following as completely as possible. This will make it unnecessary to ask you routine questions and save time for important discussions in the session.

ADDRESS (Street/city)	ZIP CODE	SOCIAL SECURITY NUMBER
HOME PHONE <input type="checkbox"/> land line <input type="checkbox"/> cell phone	WORK PHONE	OTHER/CELL PHONE
OCCUPATION	HOW LONG	OK TO LEAVE MESSAGE ON PHONE AT: <input type="checkbox"/> HOME? <input type="checkbox"/> WORK? <input type="checkbox"/> CELL?
EMPLOYED BY	HOW LONG ON PRESENT JOB	MILITARY SERVICE
BIRTHPLACE	RELIGION	PRESENT RELIGIOUS ACTIVITIES
HOW LONG HAVE YOU LIVED IN THIS AREA		SCHOOL GRADE COMPLETED
MARITAL STATUS <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	HOW LONG MARRIED	DO YOU LIVE WITH YOUR SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO
IF MARRIED PREVIOUSLY, GIVE DATES	RE FERRED BY: <input type="checkbox"/> Self <input type="checkbox"/> Doctor <input type="checkbox"/> Spouse <input type="checkbox"/> Employer <input type="checkbox"/> Other (please specify)	

DESCRIBE THE PROBLEM(S) FOR WHICH YOU SEEK ASSISTANCE;

HOW LONG HAVE THESE PROBLEMS BOTHERED YOU?

Have you ever had psychotherapy or counseling before? YES NO If YES, when and where, and for how long?

Have you ever been hospitalized for psychiatric problems? YES NO If YES, when and where, and for how long?

Have you ever had medication prescribed for psychiatric or emotional difficulties? YES NO If YES, please list all such medications, their dosages, and when you took them.

Daily tobacco usage: _____ Daily coffee/soda pop usage: _____

Height: _____ Weight: _____ I have had a recent, unplanned weight GAIN or LOSS (if yes, check ONE);

If YES, how much weight did you gain or lose? _____ and, over what period of time did this occur? _____

PLEASE CHECK THE APPROPRIATE BOX FOR ALL ITEMS BELOW

	NEVER	RARELY	FREQUENTLY	ALWAYS
1. Trouble in my job				
2. <input type="checkbox"/> Trouble going to sleep <input type="checkbox"/> Hard to stay asleep through the night				
3. <input type="checkbox"/> I feel dog-tired or <input type="checkbox"/> am easily worn-out				
4. Trouble concentrating or my mind goes blank				
5. I find myself wishing I were dead				
6. <input type="checkbox"/> Excessive anxiety or worry <input type="checkbox"/> Uncontrollable worrying				
7. I find myself easily irritated or angered				
8. Muscle tension				
9. I feel restless, keyed up, or on edge				
10. I find myself planning specific ways to commit suicide				
11. I feel depressed				
12. Less interested in activities; hard to have a good time				
13. <input type="checkbox"/> I feel worthless <input type="checkbox"/> I feel guilty about a lot of things (check one or both)				
14. I drink to help myself sleep, relax, or feel better				
15. I think about harming others				
16. I use drugs for recreation, pleasure or relaxation				
17. <input type="checkbox"/> I eat until I feel sick <input type="checkbox"/> poor appetite (check one or both)				
18. I get into physical fights with people				
19. Stomach trouble				
20. I have freaky, unearthly or weird experiences				
21. My heart pounds or beats faster				
22. I imagine terrifying things				
23. Panicky feelings				
24. <input type="checkbox"/> I am afraid to be alone <input type="checkbox"/> I'm afraid to go out alone (check one or both)				
25. I fear I may harm someone				
26. I fear things I shouldn't fear				
27. I feel apart from people				
28. It's hard for me to make friends				
29. I am bothered by <input type="checkbox"/> heat or <input type="checkbox"/> cold more than others (check one or both)				
30. I see or hear things that other people do not see or hear				
31. Trouble making decisions				
32. I have trouble keeping friends				
33. People put thoughts into my mind in strange ways				
34. <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness (check one or both)				
35. I find myself making specific plans to harm someone				
36. I drink too much				
37 I have attempted suicide in the past <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what were the approximate dates?				

38 Other: _____

FAMILY DATA SHEET

NAME	LIVING WITH YOU (Yes or No)	CITY OF RESIDENCE	AGE	IF DECEASED AGE & YEAR OF DEATH	MARITAL STATUS	OCCUPATION	HOW DO YOU (OR DID YOU) GET ALONG?
SPOUSE							
CHILDREN							
OTHERS LIVING WITH YOU							
FATHER							
MOTHER							
STEPPARENTS							
BROTHERS/SISTERS							

Whom do you turn to for emotional or social support/friendship? _____

Whom do you feel loved by? _____

Which relatives have (or had) emotional difficulties or psychiatric illnesses - including alcoholism and drug abuse?

RELATIVE	DIFFICULTY (PLEASE DESCRIBE)

1. What medications are you presently using?

2. Have you had allergic reactions or other problems with medications now or in the past? **YES** **NO**

If YES, which medications?

3. What serious medical problems, surgery or accidents have you had, or continue to have?

4. In the last six months, have you had six or more drinks during any one day? **YES** **NO**

What is your daily alcohol and/or drug usage?

5. Do you gamble? **YES** **NO**

If you gamble, have you ever lied to anyone important to you about your gambling? **YES** **NO**

If you gamble, do you feel the need to bet more and more money each time you gamble? **YES** **NO**

6. Have you had any legal difficulties?

7. What do you like to do for fun?

8. Is there any other information we should know to be able to help you?

Client signature

Date