ARGUS Psychological Services

618 10th St. – Suite 106, Huntington, WV 25701 - (304)525-9959

(Rev. May 13, 2015)

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 ☐ land line ☐ cell phone		WORK PHONE	OTHER/CELL PHONE
OCCUPATION		HOW LONG	OK TO LEAVE MESSAGE ON PHONE AT: ☐ HOME? ☐ WORK? ☐ 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 ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED		HOW LONG MARRIED	DO YOU LIVE WITH YOUR SPOUSE ☐ YES ☐ NO
IF MARRIED PREVIOUSLY, GIVE DATES	RE FERRED BY: ☐ Self ☐ Doctor ☐ Spouse ☐ Employer ☐ 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. ☐ Trouble going to sleep ☐ Hard to stay asleep through the night				
3 .☐ I feel dog-tired or ☐ am easily worn-out				
4.Trouble concentrating or my mind goes blank				
5. I find myself wishing I were dead				
6. ☐ Excessive anxiety or worry ☐ 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. ☐ I feel worthless ☐ 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. ☐ I eat until I feel sick ☐ 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.☐ I am afraid to be alone ☐ 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 ☐ heat or ☐ 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. ☐ Headaches ☐ 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 ☐ YES ☐ 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