PERSONAL DATA FORM

Name: Today's Date_________________
Last__________________________ First___________________ MI________

Date of Birth___________ Age _____ Gender Identification _______Pronoun Preference (optional) _____

Home Address:
Street___________________________ City/State_______________ Zip code__________

Email ____

Telephone #'s: Home____________ Cell___________________ Work_______________

May I call you and leave a message on your home phone? __No __Yes
May I call you and leave a message on your cell phone? ___No __Yes
May I call you and leave a message on your work phone? __No __Yes

Emergency Contact:

Name_________________________ Phone #_________________
Who referred you?_______________________________ Can I thank them for the referral?_________

Marital Status
1 Never Married
2 Married
3 Separated
4 Widowed
5 Divorced

Do you have children? __No __Yes

Present Problem:

Why are you seeking psychotherapy?____
____
____

What is your goal for this period of therapy?____
____
____

Are you currently being seen for psychotherapy or by a psychiatrist? __No __Yes
Please check any of the following that currently apply to you:

__Nightmares
__Tense
__Panicky
__Lonely
__Suicidal thoughts
__Worthless feelings
__Sleeping problems
__Worried about sex matters
__Hopeless
__Repeated thoughts
__Difficulty with anger
__Unable to make friends
__Unable to have a good time
__Frequently feel guilty

__Unhappy with present job/occupation
__Financial problems
__Bad home conditions
__Can't make decisions
__Feel that people are trying to control mind
__Homicidal ideation
__Can't concentrate
__Can't pay attention
__Bad memory
__Anxious
__Other people think there is something wrong with your mind
__Hear voices that others do not hear
__Racing thoughts
__Forget easily
__Need others too much
__Unable to find a job
__Unable to keep a job
__Eating problems
__Victim of traumatic situation (sexual assault, sexual abuse, other forms of abuse, combat, etc.)

Psychotherapy History:

Please list any previous mental health services including hospitalizations in the space below:
Therapist/Doctor Dates Reason for treatment
1. ____
2. ____
3. ____

Have you ever made a suicide attempt? If yes, please describe circumstances, how and when.
____
____

Medical History – Understanding medical problems may help me plan your treatment.

Please list any current medical problems: ____
____

Please check any of the following symptoms that currently apply to you:

__Hair loss
__Fatigue
__Dry skin
__Tremor
__Ankle swelling
__Big appetite
__Diarrhea
__Headaches
__Dizziness
__Shortness of breath
__Weight gain
__Constipation
__Weakness
__Weight loss
__Urinary problems
__Fast heartbeat
__Poor appetite
__Stomach trouble
__Fainting spells
__Menstrual issues
__Difficulty sleeping
__Sleeping too much
__Drinking too much fluid
__Blurred vision
__Deafness
__Ringing in ears
__Chest pain
__Tingling of hands and/or feet
__Nausea or vomiting
__ Problems with sexual organs

Please list all medications you currently use (both prescribed and non-prescribed):
Name of Medication Dosage Prescribed by
____
____
____