PERSONAL DATA FORM (for minor)

Person filling out this form:_____ Date:_____
Phone:_____Email:_____

Client name: Last_____ First_____ MI_____
Date of Birth_____ Age ____ School:_____Grade:_____IEP/504?_____
Client's email: _____ Cell:_____
Best primary contact person:_____ Phone:_____

Parents/primary caretakers/guardians:

Mother name:_____ Age: _____
Occupation:_____ Phone: _____
Address: _____Email: _____

Father name:_____ Age: _____
Occupation: _____ Phone: _____
Address: _____Email: _____

Emergency Contact: Name: _____ Relationship:_____
Contact phone number and address:_____

Who referred you?_____ Can I thank them for the referral?_____

Present Problem:

Why are you seeking psychotherapy?

Caregiver reason: _____
_____

Client's reason_____
_____

What is your goal for psychotherapy?_____
_____
_____

Is the client currently being seen for psychotherapy or by a psychiatrist? __No __Yes

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

__Nightmares
__Depressed
__Dishonesty/lies
__Truancy
__Suicidal thoughts
__ Homicidal thoughts
__Worthless feelings
__Sleeping problems
__Low self worth
__Hopeless
__Excessive worry
__ Difficulty with anger
__Unable to make friends
__Isolates
__Frequently feel guilty

__Pregnant
__Negative body image
__Self injury (e.g.cutting)
__Fire setting
__Poor school performance
__Eating problems
__Can't concentrate
__Can't pay attention
__Indecisive
__Anxious
__Hearing voices
__Hear voices that others do not hear
__Racing thoughts
__Hyperactive
__Forgets easily
__Alcohol use
__Other substance use/ abuse
__Stealing
__Harming animals
__Victim of traumatic situation (sexual assault, sexual abuse, other forms of abuse, traumatic loss 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.		

Has the client 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