Personal Information Form

**Identification Information:**  Intake Date:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address *(if different from above):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female

Race/Ethnicity \_\_\_\_\_\_\_\_ Religion/Spirituality \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:  Single  Engaged  Married  Separated  Divorced Widowed

Living Status:  Independent  Dependent - Relative  Dependent – Friend  Assisted Living  Homeless

Education Status:  Full-time Student Part-Time Student  Non-Student

Highest grade completed: \_\_\_\_\_\_\_\_ Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status:  Full-time Part-Time  Unemployed  Disabled  Other:

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_ Job Satisfaction

Financial Situation:  No current problems  Large indebtedness  Poverty or below-poverty income  Impulsive spending  Relationship conflicts over finances  Other:

**Emergency Contact Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How were you referred to our office?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*At times we may need to contact you in order to reschedule an appointment, provide a reminder, and/or provide some medical information.* May we contact you?  Yes No

How would you like us to contact you?  Phone Call  Text  E-mail  Letter  Other:

Can we leave a message for you  Yes No

If so at what phone number:

**Reason for Seeking Counseling:**

State the nature of your problem in your own words for which you are seeking counseling.

How long has this issue existed? \_\_\_\_

What is your most difficult relationship right now?

What is your most difficult emotion right now?

**Common problem / symptom checklist.**

Rate each of the following life issue with the following **key: no issue=0; mild issue=1; moderate issue=2; severe issue=3.**

|  |  |  |  |
| --- | --- | --- | --- |
| Marriage | Divorce/separation | Alcohol/drugs | God/faith |
| Pre-marital | Child custody | Other addictions | Church/ministry |
| Being single | Family | Children | In-laws |
| Disabled | Past hurts | Money/budgeting | Stress control |
| Sexual issues | Depression | Anger control | Loneliness |
| Codependency | School/learning | Communication | Weight control |
| Grief/loss | Fear/anxiety | Parents | Adult children |
| Work/career | Intimacy | Aging/dependency | Health |

**Immediate Family Information**

Spouse/Partner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Partner Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse/Partner Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  Male  Female

Education Status:  Full-time Student Part-Time Student  Non-Student

Highest grade completed: \_\_\_\_\_\_\_\_ Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status:  Full-time Part-Time  Unemployed  Disabled  Other:

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age relationship began: Self: \_\_\_\_\_\_ Partner: \_\_\_\_\_\_\_\_

Is your partner willing to come for counseling?  Yes:  No  Uncertain

Give brief information about any previous significant relationships: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information About Children:**

How many children? Are your children: Biological Adopted Partner’s Children

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME | AGE | SEX | EDUCATION LEVEL | RESIDENCE |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Health Information**

Rate your health: Very Good Good Average Poor: \_\_\_\_\_

Weight changes recently: None Lost Gained: \_\_\_\_\_

List all important present or past illnesses, injuries, or disabilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last medical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently taking medication?  Yes No If yes list the medication and dosage:

|  |  |  |  |
| --- | --- | --- | --- |
| MEDICATION | DOSAGE | TIMES PER DAY | REASON FOR TAKING |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Have you ever had any counseling before?  Yes No (If yes please fill in the dates, diagnosis, who treated you.)

|  |  |  |
| --- | --- | --- |
| **DATE** | **DIAGNOSIS** | **PROVIDER** |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever been abused: Physically  Yes:  No; Emotionally  Yes:  No; Sexually  Yes:  No

Spiritually  Yes:  No Age? By Whom?

Have you ever had suicidal thoughts?  Yes:  No Have you ever had suicidal intentions?  Yes:  No

Have you ever attempted suicide?  Yes:  No Age? Method?

Have you ever had homicidal thoughts?  Yes:  No Have you ever had homicidal intentions?  Yes:  No

Have you ever attempted homicide?  Yes:  No Age? Method?

Have you ever been Baker Acted?  Yes:  No If so, by whom:

Age(s) Length of stay

Have you used drugs for other than medical purposes?  Yes No If yes, check all that apply

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Substance** | **Yes** | **No** | **Past** | **Substance** | **Yes** | **No** | **Past** | **Substance** | **Yes** | **No** | **Past** |
| Alcohol |  |  |  | Pain pills |  |  |  | Marijuana |  |  |  |
| Tranquilizers |  |  |  | Stimulants |  |  |  | Inhalants (glue) |  |  |  |
| Sleeping pills |  |  |  | Narcotics |  |  |  | Other: |  |  |  |
| Hallucinogens |  |  |  | Methadone, Heroin |  |  |  | Other: |  |  |  |

Have you ever been Marchman Acted?  Yes:  No If so, by whom:

Age Treatment

**Legal History:**  No legal problems:  now on parole/probation  arrest(s) not substance-related

Arrest(s) substance-related  court ordered this treatment  Jail/prison time(s)

Total time served  Describe last legal difficulty:

**Cultural/Religious/Spiritual Background:**

Do you have any significant cultural, religious, or spiritual practices that are important to you? If so, briefly explain:

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counseling Intern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_