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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_