Please fill out this Personal Information Form to aid me in our work together.

Today's date _____

Your Name_____ age_____ date of birth_____

Address_____City/State/Zip_____

Phones: Cell_____Work_____Home_____
Please indicate if it is ***not*** okay to leave messages on any of these phones.

Who may I call in case of emergency?_____ phone_____

Who referred you to me?_____

If you are under 18, Parent/Guardian Name _____phone_____

Their relationship to you (father, mother, guardian)

What is your main reason for seeking therapy at this time?

On a scale of 1-10 (10 is "very intensely"), how intensely is this issue effecting you right now?_____

What have you done prior to our meeting to address this issue?

What have been your major medical issues, either present or past?

Medications you are taking and reason for taking them:

Who is your primary care physician?

Use these questions as a guide to tell me important information about yourself.
***You are not required to answer*. Your honesty is appreciated. Attach a page as needed.**

Who do you live with now? Name, Age, and Relationship to you (eg. John Smith, age 35, husband)

Please list previous marriages, years married, and any children from the marriages.

With whom did you live while growing up?

Do any of these people have mental illness of any kind or other significant issues/illnesses?

Do any of your other relatives have mental illness of any kind or other significant issues/illnesses?

Have you ever been diagnosed with mental illness? If yes, describe:

Are there issues about sex and/or your sexuality you wish to discuss?

Have you ever been treated for substance abuse or addiction of any kind? If yes, please describe:

Which if any of the following substances are you currently using or have you used in the past?

Substance	Age of first use	Date of last use	How often used	Usual amount
Caffeine: coffee, tea, soft drinks etc.				
Tobacco: cigarettes, chew, dip				
Alcohol: beer, wine, liquor				
Over-the-counter medications				
Marijuana/Pot				
Cocaine/Crack Cocaine				
Heroine				
Opiates				
Amphetamines				
Barbiturates				
LSD/Hallucinogens				
Benzodiazepines				
Inhalants/Huffing				
PCP				
Other illegal drugs				

On a scale of 1 (very negative) to 10 (very positive) rate the following. N/A indicates not applicable.			
How do I feel about…	Rate 1-10	**How do I feel about…**	Rate 1-10
My physical health		My body	
My friendships		My church	
My marriage or significant other		My spiritual life	
My in-laws		My school	
My relationship with my children		My neighborhood	
My income		My education	
My family in which I grew up		My roommates	
My job		My goals	
My debt		My free time activities	
My boss		My siblings	
My housing		My pets	
My mental health		My past	
My sexual life		My future	
Please attach additional pages if you wish to say more about any of the above			

Have you or any family members been hospitalized for mental illness? If yes, describe:

Was anyone in your family abusive to you or did you witness abuse?

Have you ever been assaulted in any way? If yes, describe:

Have you ever attempted suicide? If yes, when?

Do you ever have unexplainable blackouts or flashbacks of traumatic events? If yes, describe:

Are you involved in church or other religious group? If so where, and how significant is this to you?

Who are your friends and/or main sources of support?

How important is it to include prayer, the Bible, and/or your spiritual beliefs in our work?

What was your highest level of education?

How did you do in school?

What is your current employment?

What would your employer say about you?

How are you doing financially?

Have you faced a judge for any reason? If so, describe:

Please attach pages if there are other significant issues past or present you wish to address with me