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# *PERSONAL INFORMATION FORM*

**This is a <u>confidential record</u> of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment.**

*Client Name* _____ *Email* _____

*Home address*_____

*May therapist leave a message*

*Home Phone (_____)*_____ ☐ Yes ☐ No

*Cell Phone (_____)*_____ ☐ Yes ☐ No

*Work Phone (_____)*_____ ☐ Yes ☐ No

*Date of Birth* _____/_____/_____ *Age* _____ *Highest grade completed* _____

*Occupation* _____

*Employer* _____ *How long?* _____

*Person to notify in case of emergency:* _____*Phone*_____

*<u>note:</u> It is important for you and your therapist to determine together what part spiritual/religious issues will or will not take in therapy. Would you like spirituality/religious issues to be a part of your therapy? Y N Don't Know*

*Church Affiliation/Religious background (if any)*_____

*What brings you here today* _____

_____

_____

_____

*How did you find me?* _____

*Family History*

In the section below please identify if there is a family history of any of the following. If YES, please indicate the family member's relationship to you in the space provided.

List family member(s)

| | | | |
|---|---|---|---|
| Alcohol/Substance Abuse | ☐ Yes | ☐ No | _____ |
| Anxiety | ☐ Yes | ☐ No | _____ |
| Depression | ☐ Yes | ☐ No | _____ |
| Domestic Violence | ☐ Yes | ☐ No | _____ |
| Sexual Molestation | ☐ Yes | ☐ No | _____ |
| Verbal/Emotional Abuse | ☐ Yes | ☐ No | _____ |
| Eating Disorder | ☐ Yes | ☐ No | _____ |
| Schizophrenia | ☐ Yes | ☐ No | _____ |
| Bipolar Disorder | ☐ Yes | ☐ No | _____ |
| Suicide Attempts | ☐ Yes | ☐ No | _____ |

***Marital status*** –

If married: Age of Spouse _____ Date of Marriage _____

If divorced: Date of marriage to ex-spouse _____ of Divorce _____

If divorced more than once: Date of previous marriage: _____ of Divorce _____

If separated: Date of Separation _____

If involved with a "significant other" His/her name_____

- If you live together since when? _____
- Would you describe your sexual relations as satisfactory or unsatisfactory? _____

Do you have children?

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Do your children currently live with you? ☐ Yes ☐ No

Did you grow up with both parents in the home? ☐ Yes ☐ No

If your parents divorce what age were you? _____

Have you ever attempted suicide? ☐ Yes ☐ No

If YES, when? _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

- If YES, when?_____ Length of hospital stay_____

If you have ever been prescribed psychotropic medications or have been in therapy previously, please complete the following information as completely as possible:

Psychiatrist _____ Phone _____
Date and length of treatment _____

Psychotherapist _____ Phone _____
Date and length of treatment _____

Current medical conditions:

_____
_____
_____

Current prescription medications:

Name _____ dosage _____
Name _____ dosage _____
Name _____ dosage _____
Name _____ dosage _____

Do you drink Alcohol? How much? How often? _____

Do you use recreational drugs? Which ones? How often? _____

Please list and briefly describe any significant traumatic experiences, separations, and losses you have experienced in your life:

_____
_____
_____
_____