PERSONAL INFORMATION FORM

Name: ____ Date:_______

Preferred Name (Nickname): ____

Home Address: ____

City: _________________________________ State: _______ Zip Code: ___________

Home Phone Number: _________________________ Cell Phone: _______________________

Occupation: ____

Employer: ____

Date of Birth: ____________________________ Culture/Ethnicity (optional): ______________

Referred By: ____

Marital/Relationship Status: ______________________ Name of Partner: __________________

Emergency Contact: ____

Phone Number: _____________________________ How Related? _________________________

What is the problem or situation for which you are seeking help?_________________________

____

When did the problem first appear? ____

____

How would you know that the problem was solved? ___________________________________

____

Circle the following that apply to you:

Overeat	Suicide Attempts	Loss of appetite	Use Drugs
Compulsions	Suicidal thoughts	Vomiting	Smoke
Take too many risks	Insomnia	Withdrawal	Lazy
Drink too much	Panic Attacks	Eating problems	Work too hard
Concentration Difficult	Aggressive Behavior	Procrastination	Sleep disturbance
Crying	Impulsive reactions	Phobic avoidance	Temper Outbursts
Loss of Control	Difficult relationships	Anxious/Tense	School Problems

Please answer all the following carefully. This will help you!

Have you been in therapy before? Yes ______ No ______
If yes, was it helpful? ____

Reason for stopping? ____

Are you currently feeling suicidal? Yes ______ No ______

Have you ever attempting suicide? Yes ______ No ______

Have you ever been hospitalized for emotional issue(s)? Yes ______ No _______

Name/Location of hospital (s): ____

____

Dates and reasons for hospitalization(s): ____

____

Are you on medication now? Yes ______ No ______

If yes, please list: ____

____

Hobbies/Interests: ____

____

Skills/Strengths: ____

____

Therapy Goal(s): ____

____