**LISA BARBER, M.Ed, LICENSED PROFESSIONAL COUNSELOR**
**ADULT PERSONAL DATA INVENTORY**

Today's Date: _____ Whom may we thank for referring you to our office? _____

Client Name: _____ Birthdate: _____ SS#: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Ph#: _____ Work Ph#: _____ Cell Ph#: _____

Whom may we contact in case of emergency: Name _____ Relationship_____
Address _____
Phone # _____

Name of Insurance: _____ Member/Policy/Subcriber ID#: _____
Group #: _____

Email address if you would like to be contacted for administrative purposes: _____

**HEALTH INFORMATION:**
Rate your current health: Very good _____ Good _____ Average _____ Poor _____

Are you currently being treated for any medical conditions? _____

List significant illnesses, injuries, or handicap (past and present): _____

Are you currently taking medication? Yes/No If yes, please list medications:
_____

Have you been hospitalized? Yes/No If yes, please give date/reason:_____

Have you had a miscarriage or an abortion? Yes/No Date: _____

Name of Primary Physician _____ Phone#_____

**Please indicate if you or any family member has a history of**:

Alzheimer's _____
Asthma _____
Cancer _____
Epilepsy/Seizure _____
Heart Disease _____
High Blood Pressure_____
Liver/Kidney Problems_____
Stroke_____
Other_____

Anemia_____
Blood Clots _____
Diabetes_____
Heart Attack_____
Hepatitis _____
HIV/AIDS_____
Migraines_____
Tuberculosis_____
Unknown_____

Have you had counseling before? Yes/No
If yes, list name of therapist, date of service, and reason for counseling:
_____
Have you ever been tested by a psychologist? Yes/No
If yes, describe:
_____

**RELATIONSHIP/MARRIAGE INFORMATION:** Single/Married/Divorced/Other_____
Name of partner: _____ Occupation: _____
Length of relationship: _____
Length of steady dating with current partner: _____ Length of engagement: _____
Number of previous marriages and length of time: _____
Reasons for termination of previous marriages: _____
Number of children: _____ Ages of children: _____
How many children living at home? _____

Sexual Orientation: Heterosexual Homosexual Bisexual

Religious Affiliation: _____ Active church member? Yes/No

**FAMILY BACKGROUND INFORMATION:**
List your caretakers as a child and their relationship to you._____
If different from your natural parents, please explain:
_____
_____
Were your parents divorced? Yes/No If yes, what was your age at the time? _____
List the number of siblings and your place in the family (oldest, youngest, etc.): _____
_____
As a child, was your environment consistent or did you move around frequently? Please explain:
_____
Did your parents/caretakers have alcohol/drug related problems? If yes, describe:
_____
Is there any family history of mental health difficulties (depression/anxiety/drug or alcohol abuse, etc.)? Yes/No If yes please describe:
_____
_____
Were your parents/caretakers involved in spousal abuse? If yes, please describe the type of violence that occurred and the frequency: _____
_____
What disciplinary methods did your parents/caretakers use with you as a child?

| | |
|---|---|
| harsh reprimand_____ | taking privileges away_____ |
| spanking with hand _____ | time out_____ |
| spanking with objects_____ | other_____ |
| beating over body_____ | |

Do you feel that the type of disciplinary methods used were abusive? Yes/No
Specify types of abuse you may have experienced as a child:
Emotional _____ Physical _____ Sexual _____

Additional comments: _____
_____
_____

At what age did you leave home? _____

For what purpose: marriage_____ escape abuse _____
to work _____ school _____
other (specify) _____

Have you ever been arrested? Yes/No If yes please explain:

Describe your current problem symptoms for which you are seeking counseling at this time or any significant events that recently occurred that prompted you to seek counseling at this time:
_____
_____
_____

**I authorize Lisa Barber M.Ed, LPC to release any information necessary to expedite insurance claims. I authorize payment to Lisa Barber M.Ed, LPC for services described on submitted claim forms. I understand that I am responsible for payment of services, regardless of insurance coverage. I also understand that I am responsible for any charges incurred if I fail to cancel a scheduled appointment without 24 hours advance notice.**

_____ _____
Signature of Client Date

**ABOUT YOUR CONCERNS**

**Please mark all of the items that currently apply:**

- Abuse-emotional
- Abuse-neglect
- Abuse-physical
- Abuse-sexual
- Aggression
- Alcohol
- Anger
- Anxiety
- Arguing
- Attention problems
- Caffeine
- Career concerns
- Childhood issues (your own childhood)
- Children-care
- Children-custody
- Children-management
- Choices I have made
- Codependence
- Compulsive spending
- Concentration problems
- Confusion
- Crying
- Deaths
- Debt
- Decision making
- Decreased energy
- Delusions (false ideas)
- Dependence
- Depression
- Distracted
- Divorce
- Eating-making myself vomit
- Eating-overeating
- Eating-under eating
- Emptiness
- Excessively worried
- Failure
- Fatigue
- Fears
- Financial problems
- Friendship problems
- Gambling
- Grieving
- Guilt
- Headaches
- Health
- Hopeless
- Hostility
- Impulsive spending
- Impulsiveness
- Indecision
- Inferiority feelings
- Inhibitions
- Interpersonal conflicts
- Irresponsibility
- Irritability
- Judgment problems
- Laziness
- Legal matters
- Loneliness
- Loss of control
- Low frustration tolerance
- Marital conflict
- Medical Concerns
- Mood Swings
- Nicotine
- Obsessions
- Outbursts
- Oversensitive
- Overwhelmed
- Panic/Anxiety attacks
- Parenting
- Paranoid
- Perfectionism
- Phobias
- Physical pain
- Relationship problems
- Re-marriage
- Sadness
- Self cutting
- Self control
- Self-esteem
- Separation
- Sexual conflicts
- Shyness
- Sleep-nightmares
- Step-parenting
- Stress
- Suicidal thoughts/prior attempts
- Temper problems
- Violence
- Weight and diet issues
- Withdrawal, isolating self
- Worthlessness

Any other concerns?

_____

| | | |
|---|---|---|
| ○ Drugs | ○ Marital infidelity/affairs | |