



ADULT PERSONAL DATA INVENTORY

Please be sure to complete both sides of all sheets to the best of your ability.

Thank you for your comprehensive honesty in completing these initial client forms. All the information shared below is completely confidential and will not be released to anyone without your permission, unless ordered by a court of law. If you have any questions, please contact: CENTER[ED] ON WELLNESS, 1850 Colfax Avenue, Benton Harbor, MI 49022, P: 269.926.6199, F: 269.926.6780, E: info@centeredonwellness.info, W: centeredonwellness.info

SECTION I. GENERAL INFORMATION

YOUR NAME _____ DATE _____

ADDRESS _____ HOME PHONE _____ MSG OK? YES NO

CITY _____ STATE _____ ZIP _____ BUS./PAGER _____ MSG OK? YES NO

EMPLOYER _____ CELL PHONE _____ MSG OK? YES NO

OCCUPATION/JOB TITLE _____ FAX _____

LENGTH OF EMPLOYMENT _____ E-MAIL _____

MAIDEN NAME (IF ANY) _____ MILITARY VETERAN: YES NO

SEX M F BIRTH DATE ____/____/____ AGE _____ PLACE OF BIRTH _____

RELIGION _____ PLACE OF WORSHIP _____

RACIAL/ETHNIC IDENTITY: AFRICAN-AMERICAN ASIAN CAUCASIAN LATINO NATIVE AMERICAN

OTHER _____

EDUCATION

LAST YEAR OF SCHOOL COMPLETED: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 OTHER: _____

LAST SCHOOL ATTENDED _____

DEGREE / SPECIALTY (if any) _____

NEAREST RELATIVE OR FRIEND (a person whom we could contact in case of emergency, including a mental health emergency)

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ PHONE _____

REFERRED HERE BY _____ RELATIONSHIP _____

MAY WE THANK THE PERSON WHO REFERRED YOU (no confidential information about you will be released)? YES NO

WHO IS LIVING IN THE SAME HOME WITH YOU RIGHT NOW? _____

For Office Use Only:

SECTION II. RELATIONSHIP INFORMATION

CURRENT RELATIONSHIP STATUS: SINGLE DATING LIVING WITH SIGNIFICANT OTHER ENGAGED
 MARRIED SEPARATED DIVORCED SPOUSE/PARTNER DECEASED. IF SO, WHEN? _____

SPOUSE/PARTNER'S NAME _____

ADDRESS (IF DIFFERENT) _____ PHONE _____

OCCUPATION _____ EMPLOYER _____ BUSINESS PHONE _____

AGE _____ EDUCATION (LAST YR. FINISHED OR DEGREE) _____ RELIGION _____

CHILDREN: _____ LIVING? YES NO

HAVE ANY CHILDREN DECEASED? IF SO, WHO AND WHEN: _____

HAVE YOU OR A FAMILY MEMBER EVER BEEN IN PRISON? IF SO, WHO AND WHEN? _____

For Office Use Only:

SECTION III. WHAT BRINGS YOU TO CENTER[ed] ON WELLNESS?

PLEASE BRIEFLY DESCRIBE YOUR REASON FOR COMING TO SEE A COUNSELOR:

HOW STRONGLY DO YOU WANT TO CHANGE YOUR PRESENT PROBLEM ON THE SCALE BELOW:

(do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire to change)

HAS THIS PROBLEM AFFECTED YOUR: RELATIONSHIPS WORK MOOD SEXUALITY EATING WORK
 SLEEPING SCHOOL PERFORMANCE FAMILY HEALTH FINANCES ANXIETY CONCENTRATION

PLEASE LIST ANY DEATHS, SIGNIFICANT LOSSES, AND/OR TRAUMAS, WITH DATES, AND ANY RECENT MAJOR TRANSITIONS:

PLEASE PUT A CHECK BY ANYTHING BELOW YOU HAVE EXPERIENCED WITHIN THE PAST THREE MONTHS:

THOUGHT PROCESSES

- | | |
|--|---|
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Hearing voices inside head |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Experiencing flashbacks |
| <input type="checkbox"/> Seeing things others do not | <input type="checkbox"/> Out of body experiences |
| <input type="checkbox"/> Always worried | <input type="checkbox"/> Repetitive obsessive behaviors or thoughts |
| <input type="checkbox"/> Paranoid thoughts | <input type="checkbox"/> Debilitating fears |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Confused easily |
| <input type="checkbox"/> Worried about health | <input type="checkbox"/> Feel like in a fog |
| <input type="checkbox"/> No one understands me | <input type="checkbox"/> Believe being watched |

FEELINGS

- | | | |
|---|--|--|
| <input type="checkbox"/> Feel numb inside | <input type="checkbox"/> Feel like hurting someone | <input type="checkbox"/> Feeling tense |
| <input type="checkbox"/> Feeling irritable | <input type="checkbox"/> Feeling easily hurt | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Feeling guilty |
| <input type="checkbox"/> Feeling inferior worthless | <input type="checkbox"/> Not enjoying things | <input type="checkbox"/> Feeling confused |
| <input type="checkbox"/> Feeling anxious, nervous | <input type="checkbox"/> Grieving | <input type="checkbox"/> Feeling hopeless |
| <input type="checkbox"/> Feeling angry often | <input type="checkbox"/> Feeling panicky | <input type="checkbox"/> Feeling elated often |
| <input type="checkbox"/> Feeling like others are conspiring against you | <input type="checkbox"/> Lacking confidence | <input type="checkbox"/> Experiencing frequent mood shifts |
| <input type="checkbox"/> Feel like smashing things | <input type="checkbox"/> Afraid of going out | |

BEHAVIORS

- | | |
|---|--|
| <input type="checkbox"/> Explosive anger | <input type="checkbox"/> Unable to have fun |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Unable to pray |
| <input type="checkbox"/> Indecisive | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> More impatient | <input type="checkbox"/> Repetitive compulsive behaviors |
| <input type="checkbox"/> Don't like being alone | <input type="checkbox"/> Spending a lot of money |
| <input type="checkbox"/> Difficulties at work | <input type="checkbox"/> Strange sexual urges |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> Cutting or hurting self |
| <input type="checkbox"/> Can't concentrate | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Easily excited | <input type="checkbox"/> Others have voiced concern about risk behaviors |
| <input type="checkbox"/> Difficulties in relationship | |
| <input type="checkbox"/> Very restless | |
| <input type="checkbox"/> Full of energy | |

PHYSICAL CONDITIONS

- | | | |
|---|---|--|
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Cold feet and hands |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Muscles twitching or jumping | <input type="checkbox"/> Often feel sick |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Chest feels tight | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent sweating | <input type="checkbox"/> Pain down arms |
| <input type="checkbox"/> Shaky hands | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Joint/back problems |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Drugs/Take Sedatives | <input type="checkbox"/> Weight Gain |
| | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Weight Loss |

HAVE YOU EVER OR ARE YOU CURRENTLY EXPERIENCING ANY FORM OF SEXUAL ABUSE? YES NO

HAVE YOU EVER BEEN OR ARE YOU CURRENTLY IN A DOMESTIC VIOLENCE SITUATION? YES NO

DO YOU FEEL SAFE IN YOUR CURRENT LIVING SITUATION? YES NO

IS THERE ANYTHING ELSE THAT WOULD BE HELPFUL FOR YOUR THERAPIST TO KNOW? _____

WHAT ARE GOALS FOR COUNSELING (*be specific as you can*)? _____

For Office Use Only:

SECTION IV. FAMILY HISTORY

FAMILY OF ORIGIN: (Complete this section about the persons you think of as your parents.)

FATHER

MOTHER

RELATIONSHIP (check one)

BIRTH STEP ADOPTIVE
 FOSTER OTHER

BIRTH STEP ADOPTIVE
 FOSTER OTHER

STILL LIVING?

YES NO DATE OF DEATH _____

YES NO DATE OF DEATH _____

CURRENT AGE

OCCUPATION

PLACE OF RESIDENCE

EDUCATION COMPLETED

RELIGIOUS PREFERENCE

CHURCH ATTENDANCE

PER MONTH (circle one)

0 1 2 3 4 5+

0 1 2 3 4 5+

ARE YOUR BIRTH PARENTS TOGETHER? YES NO

IF THEY WERE DIVORCED, YOUR AGE AT THAT TIME _____

ARE YOUR BIRTH PARENTS MARRIED? YES NO

AGE OF MOTHER AT BIRTH? _____ FATHER? _____

WOULD YOU RATE YOUR PARENTS' MARRIAGE AS:

VERY HAPPY HAPPY AVERAGE UNHAPPY VERY UNHAPPY

DID YOU LIVE WITH A FOSTER FAMILY? YES NO

WAS THERE ABUSE? YES NO

WERE YOU ADOPTED? YES NO

AGE? _____

WOULD YOU RATE YOUR CHILDHOOD LIFE AS:

VERY HAPPY HAPPY AVERAGE UNHAPPY VERY UNHAPPY

AS A CHILD, DID YOU FEEL CLOSER TO:

YOUR FATHER YOUR MOTHER ANOTHER _____

LIST YOUR CHILDREN IN BIRTH ORDER AND NAME OF THEIR PARENT

NAME

AGE

SEX

LIVING

MARRIED

PARENT

1. _____

2. _____

3. _____

4. _____

ARE THERE ANY SPIRITUAL CONCERNS OF WHICH YOU WOULD LIKE YOUR THERAPIST TO BE AWARE? _____

For Office Use Only:

SECTION V. MEDICAL INFORMATION

RATE YOUR PHYSICAL HEALTH: GOOD AVERAGE POOR

LIST IMPORTANT PRESENT OR PAST ILLNESSES OR INJURIES: *(Include any hospitalizations and dates)*

DATE OF LAST MEDICAL EXAMINATION _____ PHYSICIAN'S NAME _____

YOUR REGULAR (PRIMARY CARE) PHYSICIAN, IF DIFFERENT _____

ARE YOU PRESENTLY TAKING PRESCRIPTION MEDICATION? YES NO

WHAT AND HOW MUCH?

MEDICATION GIVEN BY: PSYCHIATRIST PERSONAL CARE PHYSICIAN N/A

DO YOU SMOKE? YES NO HOW MUCH? _____

DO YOU DRINK ALCOHOL? YES NO HOW MUCH? _____

DO YOU USE OTHER SUBSTANCES AND IF SO WHAT, HOW MUCH, AND HOW OFTEN? _____

ANY OTHER COMPULSIVE BEHAVIOR? _____

HAVE YOU EVER BEEN TREATED OR SEEN BY A PSYCHIATRIST? YES NO WHEN? _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

HAVE YOU EVER BEEN TREATED OR SEEN BY ANOTHER COUNSELOR? YES NO WHEN? _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

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