Date ___/___/_____

Sara Lee, LCSW
Personal Information Form

Name_____
Address_____
Email_____
Cell #_____ Do you text from this number? Yes No
Other #_____ (specify work, home, etc.)
Male/Female_____ Age_____ Date of birth_____
Ethnic background_____
Relationship status_____
[single, (re)married, dating, cohabitating, engaged, separated, divorced, widowed]
Children (names and ages) _____
With whom do you live? _____
Highest level of education_____
Occupation_____
Employer_____
Referred by_____
May I express thanks to him/her for the referral? Yes No
In case of an emergency, I give permission for my therapist to contact the following:

Name	Best phone number	Relationship

Describe your primary concern(s) and why you decided to seek help at this time.

_____
_____
_____

What are your goals, hopes and expectations regarding counseling?

_____
_____
_____

Have you ever received counseling before? Yes No
If yes,with whom, where, when, for what reasons? Include contact phone/address

_____
_____

What was the date of your last physical exam? _____
Current and significant past illnesses, health conditions _____

_____

Current medications and reason(s) for taking

_____
_____

Name and phone number of primary physician _____

Have you ever been prescribed or taken any medication for any psychological problems? Yes No
If yes, provide the name of the medication, dosage, & dates taken.

_____

If yes, provide the name and phone number of prescribing doctor:

_____

Have you ever been hospitalized for any mental, emotional or behavioral problems? Yes No
If yes, when, where and for what reasons? _____

_____

Did or does anyone in your family have a mental illness or emotional problems? Yes No
If yes, who and why? _____

_____

Have you experienced problems related to any of the following?
Please mark **P** if you experienced it in the **past** and **C** if you are **currently** experiencing it. Please put a * next to those that are significant to you NOW.

	Difficulty concentrating		Spiritual
	Relationship difficulties		Fidgety and restless
	Self-hatred		Affairs/infidelity
	Fear or panic		Loss of Appetite
	Pornography		Underlying sadness
	Sleep problems		Loss or grief
	Up and down mood cycles		Loss of interest in work or activities
	Compulsive thoughts or behaviors		Legal problems
	Difficulties in sexual function/performance		Hearing or seeming things that others do not
	Thoughts of death		Indecisiveness
	Difficulties with emotions		Feeling misunderstood or judged
	Difficulty trusting the motives of others		Intrusive thoughts or impulses
	Gender/sexual identity issue		Depression /hopelessness
	Anger, frustration or rage issues		Work problems
	Overeating/undereating &/or purging		Insecurity/poor self-image
	Alcohol/Substance abuse/misuse		Distressing fantasies
	Self-harm/cutting		Addictions
	Anxiety/worry		Abortion
	Guilt or shame		Traumatic events (including abuse)
	Feelings of worthlessness		Flashbacks
	Promiscuity		Isolation

Further details about significant symptoms: _____

_____

Have you ever had suicidal thoughts? Yes No Suicidal attempts? Yes No
If yes, please describe and give date(s): _____

_____

Would you like spirituality to be part of the counseling process? Yes No
Is there any other information you think is important for your therapist to know?

_____

_____