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PERSONAL INFORMATION FORM

ADULT

Name:_____, _____
Last First Middle (Maiden)

Address:_____
Street Apt, etc. City State ZIP

Telephone: Home ( )_____ Work ( )_____ Cell ( )_____

Age:_____ Sex: _____ Referred by:_____

Date of Birth:_____ Place of Birth:_____

Religious Preference:_____ Are you Adopted? N_ Y_ (at age?_____)

Military Service:_____⇒
(dates & place of service)

Describe your life: Very happy ___ Happy ___ Average ___ Unhappy ___ Very Unhappy ___

I. FAMILY DATA - for Step-Parents, give same information on reverse side of this sheet ⇒

A. Father's Name:_____ Mother's Name:_____

Age:_____ (or age at death):_____ Age:_____ (or age at death):_____

Nationality:_____ Nationality: _____

Occupation:_____ Occupation: _____

Religious Preference:_____ Religious Preference:_____

Military Service:_____ Military Service: _____

_____ ⇒ _____⇒

B. Rate your parents' marriage: Very good___ Good___ Average___ Poor___

C. Do your parents continue to live together?_____ (If no, complete the following:)

Dates of ( )separation/ ( )divorce/ ( )death:_____ Your age(s) at the time(s):_____

Father: Remarried?_____; when:_____ Mother: Remarried?_____; when:_____

D. List your siblings (brothers, sisters), then any step-siblings and/or half-siblings, according to age:

	Name	Age	Sex	Education	Occupation	Marital status	Adopted?
1)							
2)							
3)							
4)							
5)							

&) [Continue on reverse of page if necessary for this and other questions] ⇒

II. MARITAL STATUS

A. If Married: Length of Engagement:_____ Number of years married:_____

Spouse's name:_____ Age:____ Occupation:_____ Education:_____

B. If Divorced &/or Widowed:

Ex-Spouse(s) name:	Age	Occupation	Education	Dates of ( )Mar/ ( )Div/ ( )Death
1)_____	___	_____	_____	_____
2)_____	___	_____	_____	_____⇒

C. Describe your marriage(s):_____

_____⇒

D. Children

Name	Age	Sex	School/Year	At Home?/Married?	Adopted?
1)_____	____	____	_____	_____	___
2)_____	____	____	_____	_____	___
3)_____	____	____	_____	_____	___
4)_____	____	____	_____	_____	___
5)_____	____	____	_____	_____	___ ⇒

III. OCCUPATION

A. Present Employment:_____

Name of Employer:_____

Length of Employment: _____years, _____months. Income/Salary:_____

Do you like or dislike your present employment?_____⇒

B. Past Employment:

Name of Employer	Length of Employment	Like/Dislike	Income/Salary
1)_____	_____	_____	_____
2)_____	_____	_____	_____⇒

IV. ANY CONTACTS WITH PSYCHIATRIC, PSYCHOLOGICAL, MENTAL HEALTH SERVICES, ALSO SUBSTANCE ABUSE SERVICES, SELF-HELP GROUPS, ETC

Therapist/Agency/Hospital	Date(s)	Medication?
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____⇒

V. YOUR EMOTIONAL STATUS & HISTORY

1. Evaluate yourself from 1 to 5 in the following categories:

[ ] Health 1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent

[ ] Self Esteem [ ] Expressing Your Emotions

[ ] Well-Being [ ] Feeling Your Emotions

[ ] Sexual Enjoyment [ ] Freedom From Pain

[ ] Ability to Handle Stress [ ] Enjoyment of Life

2. (CIRCLE) the emotions you often feel. ~~CROSS OUT~~ those you rarely feel.

Sad Angry Fear Joy Grief Rage Anxiety Love Confident Embarrassed Peace Restless Righteousness Guilty Excited Aggravated Shame Sexual Feeling Terror Inadequate Tense Regret Helpless Bored Lonely Jealous Optimistic Panic Envy Energetic Annoyed

3. History and Current Situations (Check either or both columns as appropriate)

	Past ˇ	***Now*** ˇ	
a	[ ]	[ ]	frequent aches/pains in my_____
b	[ ]	[ ]	accidents/surgeries
c	[ ]	[ ]	physical abuse - [ ]receive/[ ]give
d	[ ]	[ ]	emotional abuse - [ ]receive/[ ]give
e	[ ]	[ ]	sexual abuse - [ ]receive/[ ]give
f	[ ]	[ ]	infidelity - [ ]partner/[ ]own
g	[ ]	[ ]	suicidal thoughts
h	[ ]	[ ]	suicide attempts
i	[ ]	[ ]	anxiety attacks
j	[ ]	[ ]	depression
k	[ ]	[ ]	extended grief
l	[ ]	[ ]	low back pain
m	[ ]	[ ]	alcohol or drug overuse
n	[ ]	[ ]	hypochondria
o	[ ]	[ ]	nervous breakdowns
p	[ ]	[ ]	eating disorders
q	[ ]	[ ]	digestive problems
r	[ ]	[ ]	colonic disturbances
s	[ ]	[ ]	sexual dysfunction
t	[ ]	[ ]	PMS / menstrual distress
u	[ ]	[ ]	recent death of loved one(s)
v	[ ]	[ ]	allergies
w	[ ]	[ ]	asthma
x	[ ]	[ ]	jealousy
y	[ ]	[ ]	bed wetting, other urinary problems

	Past ˇ	***Now*** ˇ	
aa	[ ]	[ ]	overeat / eating problems
bb	[ ]	[ ]	take illegal drugs
cc	[ ]	[ ]	aggressive behavior
dd	[ ]	[ ]	temper outbursts/problems
ee	[ ]	[ ]	sleep disturbances/problems
ff	[ ]	[ ]	compulsions
gg	[ ]	[ ]	smoke
hh	[ ]	[ ]	overwork
ii	[ ]	[ ]	can't keep job
jj	[ ]	[ ]	nervous tics
kk	[ ]	[ ]	crying
ll	[ ]	[ ]	take too many risks
mm	[ ]	[ ]	tendency to hurt myself
nn	[ ]	[ ]	odd behavior
oo	[ ]	[ ]	procrastinate
pp	[ ]	[ ]	concentration difficulties
qq	[ ]	[ ]	social withdrawal
rr	[ ]	[ ]	sexual compulsion
ss	[ ]	[ ]	teeth grinding (bruxism)
tt	[ ]	[ ]	TMJ
uu	[ ]	[ ]	lying / truth-telling issues
ww	[ ]	[ ]	diabetes
xx	[ ]	[ ]	migraines/frequent headaches
yy	[ ]	[ ]	severe financial difficulties
zz	[ ]	[ ]	reading - writing difficulties

Do you remember your dreams? __frequently __occasionally __seldom __never.

Are they: __pleasant __troubled __nightmares __vary

Recurrent themes:

VI. YOUR MEDICAL & PSYCHOLOGICAL HISTORY

List any operations, medical procedures, or hospitalizations for medical, mental, emotional, drug, or alcohol problems: (except as noted on p2 IV) Date

_____ _____

_____ _____

_____ _____⇒

Any additional medical/mental health information:

_____⇒

YOUR PRIMARY PHYSICIAN Name: _____

Address: _____ City & Zip _____

Phone: _____ Date last seen _____

Reason _____

Do you use the following?

	How long used?	How much used?
Caffeine (coffee, tea, cola)	_____	_____
Alcohol	_____	_____
Tobacco	_____	_____
Non-Prescription Drugs	_____	_____

Prescriptions drugs taken past 6 months	Current Frequency	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____⇒

VII. EDUCATIONAL HISTORY

Highest grade completed_____ When_____ Where_____

Trade schools or Continuing Education?_____

How did you do in school?_____

How did you feel about school?_____

Do you want to return to school?_____ When_____

_____ _____

Today's Date Your Signature