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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:

- | | |
|---|---|
| <input type="checkbox"/> Health | 1=Poor 2=Fair 3=Good 4=Very Good 5=Excellent |
| <input type="checkbox"/> Self Esteem | <input type="checkbox"/> Expressing Your Emotions |
| <input type="checkbox"/> Well-Being | <input type="checkbox"/> Feeling Your Emotions |
| <input type="checkbox"/> Sexual Enjoyment | <input type="checkbox"/> Freedom From Pain |
| <input type="checkbox"/> Ability to Handle Stress | <input type="checkbox"/> 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)

<i>Past</i>	<i>Now</i>		<i>Past</i>	<i>Now</i>	
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
a	<input type="checkbox"/>	<input type="checkbox"/> frequent aches/pains in my _____	aa	<input type="checkbox"/>	<input type="checkbox"/> overeat / eating problems
b	<input type="checkbox"/>	<input type="checkbox"/> accidents/surgeries	bb	<input type="checkbox"/>	<input type="checkbox"/> take illegal drugs
c	<input type="checkbox"/>	<input type="checkbox"/> physical abuse - <input type="checkbox"/> receive/ <input type="checkbox"/> give	cc	<input type="checkbox"/>	<input type="checkbox"/> aggressive behavior
d	<input type="checkbox"/>	<input type="checkbox"/> emotional abuse - <input type="checkbox"/> receive/ <input type="checkbox"/> give	dd	<input type="checkbox"/>	<input type="checkbox"/> temper outbursts/problems
e	<input type="checkbox"/>	<input type="checkbox"/> sexual abuse - <input type="checkbox"/> receive/ <input type="checkbox"/> give	ee	<input type="checkbox"/>	<input type="checkbox"/> sleep disturbances/problems
f	<input type="checkbox"/>	<input type="checkbox"/> infidelity - <input type="checkbox"/> partner/ <input type="checkbox"/> own	ff	<input type="checkbox"/>	<input type="checkbox"/> compulsions
g	<input type="checkbox"/>	<input type="checkbox"/> suicidal thoughts	gg	<input type="checkbox"/>	<input type="checkbox"/> smoke
h	<input type="checkbox"/>	<input type="checkbox"/> suicide attempts	hh	<input type="checkbox"/>	<input type="checkbox"/> overwork
i	<input type="checkbox"/>	<input type="checkbox"/> anxiety attacks	ii	<input type="checkbox"/>	<input type="checkbox"/> can't keep job
j	<input type="checkbox"/>	<input type="checkbox"/> depression	jj	<input type="checkbox"/>	<input type="checkbox"/> nervous tics
k	<input type="checkbox"/>	<input type="checkbox"/> extended grief	kk	<input type="checkbox"/>	<input type="checkbox"/> crying
l	<input type="checkbox"/>	<input type="checkbox"/> low back pain	ll	<input type="checkbox"/>	<input type="checkbox"/> take too many risks
m	<input type="checkbox"/>	<input type="checkbox"/> alcohol or drug overuse	mm	<input type="checkbox"/>	<input type="checkbox"/> tendency to hurt myself
n	<input type="checkbox"/>	<input type="checkbox"/> hypochondria	nn	<input type="checkbox"/>	<input type="checkbox"/> odd behavior
o	<input type="checkbox"/>	<input type="checkbox"/> nervous breakdowns	oo	<input type="checkbox"/>	<input type="checkbox"/> procrastinate
p	<input type="checkbox"/>	<input type="checkbox"/> eating disorders	pp	<input type="checkbox"/>	<input type="checkbox"/> concentration difficulties
q	<input type="checkbox"/>	<input type="checkbox"/> digestive problems	qq	<input type="checkbox"/>	<input type="checkbox"/> social withdrawal
r	<input type="checkbox"/>	<input type="checkbox"/> colonic disturbances	rr	<input type="checkbox"/>	<input type="checkbox"/> sexual compulsion
s	<input type="checkbox"/>	<input type="checkbox"/> sexual dysfunction	ss	<input type="checkbox"/>	<input type="checkbox"/> teeth grinding (bruxism)
t	<input type="checkbox"/>	<input type="checkbox"/> PMS / menstrual distress	tt	<input type="checkbox"/>	<input type="checkbox"/> TMJ
u	<input type="checkbox"/>	<input type="checkbox"/> recent death of loved one(s)	uu	<input type="checkbox"/>	<input type="checkbox"/> lying / truth-telling issues
v	<input type="checkbox"/>	<input type="checkbox"/> allergies	ww	<input type="checkbox"/>	<input type="checkbox"/> diabetes
w	<input type="checkbox"/>	<input type="checkbox"/> asthma	xx	<input type="checkbox"/>	<input type="checkbox"/> migraines/frequent headaches
x	<input type="checkbox"/>	<input type="checkbox"/> jealousy	yy	<input type="checkbox"/>	<input type="checkbox"/> severe financial difficulties
y	<input type="checkbox"/>	<input type="checkbox"/> bed wetting, other urinary problems	zz	<input type="checkbox"/>	<input type="checkbox"/> 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