PERSONAL INFORMATION FORM

Name_____ Date_____

Home Address_____

City_____ Zip_____

Home Phone _____Cell Phone_____

Occupation _____

Employer_____

Date of Birth_____ Culture/Ethnicity (optional) _____

Referred by _____

Marital/Relationship Status_____Name of Partner_____

Emergency Contact_____

Phone _____ How Related? _____

What brings you here? _____

_____

When did this begin?_____

(OVER)

Circle all the following that apply to you:

Overeat	Suicide attempts	Loss of appetite	Use drugs
Compulsions	Suicidal thoughts	Vomiting	Smoke
Take too many risks	Insomnia	Withdrawal	Lazy
Drink too much	Panic attacks	Eating problems	Work too hard
Concentration difficult	Aggressive behavior	Procrastination	Sleep disturbance
Crying	Impulsive reactions	Phobic avoidance	Temper outbursts
Loss of control	Difficult relationships	Anxious/Tense	School problems

Please answer all the following carefully. This will help me help you!

Have you ever been in therapy before? YES_____ NO_____

If yes, was it helpful?_____

Reason for stopping?_____

Have you ever attempted suicide? YES_____ NO_____

Are you on any medication now? YES_____ NO_____

If yes, please list: _____

Have you ever been hospitalized for an emotional issue? YES_____ NO_____

Location of hospital(s)_____

Dates and reasons for hospitalization(s)_____

_____

To coordinate your treatment, and especially if you are taking an antidepressant, anti-anxiety, or other psychiatric medication, I may need to be in contact with your physician and/or psychiatrist. I will discuss this with you **before** contacting your physician.

Physician's Name_____ Phone_____

Notes_____

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