



# PERSONAL INFORMATION & ASSESSMENT

This confidential information form will help us to develop a treatment plan.  
Please complete it as carefully as you can.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ May we contact you at this number?  Yes  No

Home Phone: \_\_\_\_\_ May we contact you at this number?  Yes  No

Work Phone: \_\_\_\_\_ May we contact you at this number?  Yes  No

Email Address: \_\_\_\_\_ May we contact you by email?  Yes  No

Referred by: \_\_\_\_\_ Relationship? \_\_\_\_\_

In an emergency, contact: \_\_\_\_\_ Relationship? \_\_\_\_\_ Phone: \_\_\_\_\_

## EMPLOYMENT

Employer/Company: \_\_\_\_\_ Job Title/Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

How satisfied are you with your current work?  Very satisfied  Satisfied  Unsatisfied  Very unsatisfied

If you could do any other kind of work, what would you do? \_\_\_\_\_

## MARITAL STATUS

Single  Separated: How long? \_\_\_\_\_

Engaged: How long? \_\_\_\_\_  Divorced: How long? \_\_\_\_\_

Married: How long? \_\_\_\_\_  Widowed: How long? \_\_\_\_\_

Partnered: How long? \_\_\_\_\_

Do you have children?  No  Yes *If yes, please list their names & ages:*  
\_\_\_\_\_

## EDUCATION (CHECK HIGHEST LEVEL COMPLETED)

Grade School  High School  College  Graduate School

## MILITARY HISTORY

None  Yes *If yes, list Branch & Years of Service:* \_\_\_\_\_

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**HEALTH INFORMATION**

Please rate your physical health:     Very good     Good     Average     Declining     Poor

What is your approximate weight? \_\_\_\_\_ lbs.    Recent weight change? Lost \_\_\_\_\_ lbs. or Gained \_\_\_\_\_ lbs.

Primary Care Physician: \_\_\_\_\_ Year of Last Medical Exam or Office Visit: \_\_\_\_\_

Office Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**\* Please list any medical conditions or problems you are CURRENTLY experiencing or being treated for:**

<u>Condition/Problem</u>	<u>Medications/Treatments</u>	<u>Name of Treatment Provider</u>
1. _____	_____	_____
2. _____	_____	_____

**\* Please list any significant, PAST illnesses or injuries that you have experienced or been treated for:**

<u>Past Illness or Injury</u>	<u>Approximate Date(s)</u>
1. _____	_____
2. _____	_____

**\* Are you currently taking or being treated with any of the following (please specify):**

- Yes     No    Antidepressants or other psychiatric medications? \_\_\_\_\_
- Yes     No    Herbal or other natural/alternative supplements? \_\_\_\_\_
- Yes     No    Hormone replacement or supplementation of any type? \_\_\_\_\_
- Yes     No    Vitamin or mineral supplements? \_\_\_\_\_

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**SLEEP PATTERNS**

- Yes     No    Do you have normal, restful sleep?
- Yes     No    Do you feel the need to nap?
- Yes     No    Do you have trouble going to sleep?
- Yes     No    Do you have trouble staying asleep?
- Yes     No    Do you snore?
- Yes     No    Do you wake up frequently?
- Yes     No    Are there medications, supplements, or other that you have taken to help with sleep?  
*Please specify:*  
\_\_\_\_\_

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**PRIOR COUNSELING OR PSYCHOTHERAPY**

Have you ever been in psychotherapy or counseling before?     No     Yes

Treatment Provider/Dates: \_\_\_\_\_

How would you describe your prior counseling experiences?     Very helpful     Helpful     Somewhat helpful     Not helpful

Have you ever seen or been treated by a psychiatrist?     No     Yes

Treatment Provider/Dates: \_\_\_\_\_

Have you ever been hospitalized for stress or for other mental health reasons?     No     Yes

Hospital(s)/Dates: \_\_\_\_\_

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**SYMPTOMS**

Please check any of the following that apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Feel sad, depressed, "blue" more often than not                                 | <input type="checkbox"/> Experience intense fears that limit me significantly  |
| <input type="checkbox"/> Feel tired, fatigued, low energy, or slowed down                                | <input type="checkbox"/> Have trouble getting my breath sometimes  |
| <input type="checkbox"/> Cry easily  | <input type="checkbox"/> Suddenly feel scared for no apparent reason   |
| <input type="checkbox"/> Feel hopeless about the future  | <input type="checkbox"/> Sudden chills or hot flashes  |
| <input type="checkbox"/> Feel unable to make a difference in my situation                                | <input type="checkbox"/> Heart pounding/racing   |
| <input type="checkbox"/> Poor concentration or motivation  | <input type="checkbox"/> Chest pains   |
| <input type="checkbox"/> Unable to forgive myself or blame myself for things                             | <input type="checkbox"/> Trembling/shaking   |
| <input type="checkbox"/> Feel lonely or socially isolated from others                                    | <input type="checkbox"/> Feel nervous when left alone  |
| <input type="checkbox"/> Low self esteem or feel inferior to others at times                             | <input type="checkbox"/> Feel stressed much of the time  |
| <input type="checkbox"/> Unable to ask for what I need or want   | <input type="checkbox"/> Anxiety/panic   |
| <input type="checkbox"/> Unable to say no  | <input type="checkbox"/> Sweating  |
| <input type="checkbox"/> Find it difficult to express anger  | <input type="checkbox"/> Feel faint or dizzy   |
| <input type="checkbox"/> Have unresolved anger, bitterness or resentment                                 | <input type="checkbox"/> Tingling or numbness  |
| <input type="checkbox"/> Feel the need to please others excessively                                      | <input type="checkbox"/> Fear of dying   |
| <input type="checkbox"/> Need to tell "white" or even blatant lies                                       | <input type="checkbox"/> Fear of going crazy   |
| <input type="checkbox"/> Unable to believe in my own worth   | <input type="checkbox"/> Feeling trapped or caught   |
| <input type="checkbox"/> Feel out of touch with my genuine needs & feelings                              | <input type="checkbox"/> Feel a lump in my throat  |
| <input type="checkbox"/> Emotions seems to control my behavior   | <input type="checkbox"/> Headaches/migraines   |
| <input type="checkbox"/> Unable to have fun or not allowing myself to have fun                           | <input type="checkbox"/> Nausea or often sick to my stomach  |
| <input type="checkbox"/> Not interested in things I usually enjoy  | <input type="checkbox"/> Tend to avoid certain things, places, activities out of fear                                |
| <input type="checkbox"/> Feel like I have little power or influence over my life                         | <input type="checkbox"/> Feel afraid of open or large spaces   |
| <input type="checkbox"/> Feel like a victim much of the time   | <input type="checkbox"/> Have recurring dreams or nightmares   |
| <input type="checkbox"/> Keep making negative or self-defeating choices that end up hurting me or others | <input type="checkbox"/> Unwanted or intrusive thoughts about abuse, trauma or other difficult events or experiences |
| <input type="checkbox"/> Rarely express or receive positive, physical affection                          | <input type="checkbox"/> Easily startled   |
| <input type="checkbox"/> Loss of sexual interest or pleasure   | <input type="checkbox"/> Difficult to remember events in childhood or grade school                                   |
| <input type="checkbox"/> Lack meaningful/fulfilling connection to another person, family, group or pet   | <input type="checkbox"/> Sometimes feel detached or outside of my body watching myself do things                     |
| <input type="checkbox"/> Feel criticized <i>by</i> others  | <input type="checkbox"/> Sometimes feel that I am not real   |
| <input type="checkbox"/> Feel critical <i>of</i> others  | <input type="checkbox"/> Sometimes feel that things around me are not real   |
| <input type="checkbox"/> Use alcohol, drugs, sex, work, food, etc. to cope                               | <input type="checkbox"/> Lose track of time or have blank spells   |
| <input type="checkbox"/> Changes in appetite (circle: more or less )                                     | <input type="checkbox"/> Have flashbacks or vivid memories of certain events   |
| <input type="checkbox"/> Changes in sleep (circle: more or less )  | <input type="checkbox"/> Obsessive thoughts or compulsive behaviors  |
| <input type="checkbox"/> Thoughts of hurting myself or ending my life                                    | <input type="checkbox"/> Have been in a physically or verbally abusive relationship                                  |
| <input type="checkbox"/> Previous suicide attempt(s): When? _____  | <input type="checkbox"/> Racing thoughts/difficulty holding onto an idea   |
| <input type="checkbox"/> Thoughts of hurting someone else  | <input type="checkbox"/> I hear or see things that other people don't  |
| <input type="checkbox"/> Feel angry or irritable   | <input type="checkbox"/> I hear voices inside my head  |
| <input type="checkbox"/> Easily agitated, annoyed or frustrated  | <input type="checkbox"/> Often feel I am not thinking clearly  |
| <input type="checkbox"/> Find it difficult to control my temper  | <input type="checkbox"/> Other problems or symptoms? _____   |
| <input type="checkbox"/> Find it difficult to control my spending or gambling                            | _____  |

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**ALCOHOL & DRUG USE**

- Are you concerned about your use of:  Alcohol  Prescription medications  Over-the-counter medications
- Caffeine  Other \_\_\_\_\_

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**RELATIONSHIPS**

How would you rate your relationships with the following people?

Boss or co-workers	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Very poor
Spouse or partner	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Very poor
Friends	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Very poor
Parents	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Very poor
Children	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	<input type="checkbox"/> Very poor

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**PARENTAL FAMILY HISTORY**

Did your birth parents raise you?  No  Yes

Were your parents divorced?  No  Yes How old were you when they divorced? \_\_\_\_\_

Were you reared by foster, adoptive, or step parents?  No  Yes

If yes, please explain: \_\_\_\_\_

Have you experienced the death of one or both of your parents?  No  Yes

Rate your parents' relationship:  Very unhappy  Unhappy  Average  Happy

As a child, to whom did you feel emotionally closer?  Mother  Father  Another: \_\_\_\_\_

Rate your childhood experience:  Happy  Average  Unhappy  Very unhappy

Please list the first names of your sisters & brothers in birth order: \_\_\_\_\_

\_\_\_\_\_

What religious training or practice did you have as a child? \_\_\_\_\_

What is your current religious or spiritual practice, if any? \_\_\_\_\_

How did your family handle conflict? \_\_\_\_\_

How did they express affection? \_\_\_\_\_

What is your earliest childhood memory? \_\_\_\_\_

What positive aspects of your childhood can you recall now? \_\_\_\_\_

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**TRAUMA**

Please check any of the following you have experienced or are concerned about now:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Physical/verbal abuse                                    | <input type="checkbox"/> Childhood sexual abuse/molestation | <input type="checkbox"/> Victim of crime/assault  |
| <input type="checkbox"/> Alcoholism/drug abuse in family                          | <input type="checkbox"/> Rape/sexual assault in childhood   | <input type="checkbox"/> Death of family member or loved one during childhood                                 |
| <input type="checkbox"/> Neglect in childhood                                     | <input type="checkbox"/> Rape/sexual assault in adulthood   | <input type="checkbox"/> Family member or loved one with serious mental or physical illness in your childhood |
| <input type="checkbox"/> Major medical illness, treatment or surgery in childhood |   |   |
| <input type="checkbox"/> Other (please specify): _____                            |   |   |

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**LEGAL CONCERNS**

Have you ever been arrested?       No     Yes    If yes, why? \_\_\_\_\_

Have you ever been taken to court?       No     Yes    If yes, why? \_\_\_\_\_

Are you currently experiencing any stress related to legal issues?       No     Yes    If yes, what? \_\_\_\_\_

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**HOBBIES**

Please list things you enjoy doing:

\_\_\_\_\_

What do you find rewarding about these activities?

\_\_\_\_\_

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**TREATMENT GOALS & PLANNING**

Please describe what improvements or changes you would like to see in response to counseling:

\_\_\_\_\_

What would you envision as a reasonable timeframe to accomplish these goals?

\_\_\_\_\_

What thoughts, attitudes, or beliefs about yourself or your life situation, do you feel need to change to facilitate your mental and physical health and well-being?

\_\_\_\_\_

Is there any additional information you feel is important to communicate about yourself that would help me in assisting you?

\_\_\_\_\_

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**PATIENT AUTHORIZATION**

*Please sign your initials next to the statements below to indicate your understanding that:*

\_\_\_\_\_ As the authorizing signature, you assume sole financial responsibility for services rendered.

\_\_\_\_\_ You are personally responsible for payment of all appointments not cancelled 24 hours in advance.

\_\_\_\_\_ The therapist may contact you at your home, work, or mobile phone or by email to confirm or schedule appointments as you have indicated on the front of this form.

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print your name: \_\_\_\_\_

**THANK YOU FOR RETURNING THIS FORM PROMPTLY**