PERSONAL DATA FORM – ADULT

Name: Today's Date:_____
Last_____ First_____ MI_____
Date of Birth_____ Age ___ Gender (circle): M F
Email_____
Home Address:
Street_____ City/State_____ Zip code_____

Telephone #'s: Home_____ Work_____ Cell_____

Emergency Contact:
Name_____ Phone #_____ Relationship_____

Present Problem
Why are you seeking psychotherapy?_____
_____
_____

What is your goal for this period of therapy?_____
_____
_____

Are you currently being seen for psychotherapy or by a psychiatrist? __No __Yes

Please check any of the following that currently apply to you:

__Nightmares
__Tense
__Panicky
__Lonely
__Suicidal thoughts
__Worthless feelings
__Worried about sex matters
__Hopeless
__Repeated thoughts
__Difficulty with anger
__Unable to make friends
__Unable to have a good time
__Frequently feel guilty
__Need others too much
__Unable to find a job
__Unable to keep a job
__Sleeping problems
__Unhappy with present job/occupation
__Financial problems
__Bad home conditions
__Can't make decisions
__Feel that people are trying to control mind
__Homicidal ideation
__Can't concentrate
__Can't pay attention
__Other people think there is something wrong with your mind
__Hear voices that others do not hear
__Racing thoughts
__Forget easily
__Bad memory
__Anxious
__ Eating problems
__Victim of traumatic situation (rape, incest, abuse, war, etc.)

Psychotherapy History
Please list any previous mental health services including hospitalizations in the space below:

	Therapist/Doctor	Dates	Reason for treatment
1.			
2.			
3.			

Have you ever made a suicide attempt? If yes, please describe circumstances, how and when.
_____
_____

Has anyone in your family had psychological or psychiatric problems? If yes, please describe.
_____

Has anyone in your family had alcohol or drug problems? If yes, please describe.

_____

Please list all medications you currently use (both prescribed and non-prescribed):

Name of Medication Dosage Prescribed by

_____

_____

Do you have any addictions to prescription medications? __No __Yes

Alcohol/Drug History:

Are you in treatment for alcohol or drug use?_____

How much alcohol do you consume each week?_____

Any drug or alcohol related arrests? __No __Yes

Please check which of the following substances you have used:

Substance	Ever used?	Used in past year?	Frequency?	Comments
Caffeine				
Tobacco				
Inhalants/Glue				
Marijuana/Hashish (pot)				
Stimulants/Amphetamines (speed)				
Sedatives/Barbiturates (downers)				
Xanax/Valium/Librium (tranquilizers)				
LSD/Psychedelics/PCP (angel dust)				
Cocaine/Crack				
Heroin/Opiates				

Please check off your personal strengths.

__Likable
__Appearance
__Hopeful
__Emotionally stable
__Healthy
__Adaptable
__Tolerant
__Resourceful
__Confident
__Creative
__Sensitive
__Intelligent
__Witty
__Persistent
__Loving
__Other _____

List your best qualities and strengths if unnamed above. _____

_____

May I call you and leave a message on your home phone? __No __Yes

May I call you and leave a message on your work phone? __No __Yes

How did you hear about me? I would like to contact this person to thank them for the referral. If this is ok, please list their name and sign your name below.

Referred by: _____

Your Signature:_____