

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 | Take 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 _____