



**PERSONAL DATA**

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Client Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Which one would you prefer your therapist to try first? \_\_\_\_\_ May he/she leave a message at hm? \_\_\_ wk? \_\_\_ cell? \_\_\_

Age \_\_\_ Birthdate \_\_\_\_\_ Education/Highest grade completed? \_\_\_\_\_

Marital Status \_\_\_\_\_ Satisfaction re: marital status \_\_\_\_\_

Number, ages, & gender of children \_\_\_\_\_ With whom do they live? \_\_\_\_\_

Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Previous Occupations \_\_\_\_\_

Would you like spirituality/religious issues to be a part of your therapy? Yes / No / Don't Know

Medication and Substance History: Please indicate with an "X" how often you use any of the following:

	<i>Daily</i>	<i>Frequently</i>	<i>Occasionally</i>	<i>Never</i>
Appetite Suppressants.....	_____	_____	_____	_____
Sedatives/Tranquilizers.....	_____	_____	_____	_____
Sleeping Pills.....	_____	_____	_____	_____
Stimulants.....	_____	_____	_____	_____
Narcotics.....	_____	_____	_____	_____
Pain Killers.....	_____	_____	_____	_____
Alcohol.....	_____	_____	_____	_____
Nicotine.....	_____	_____	_____	_____
Caffeine.....	_____	_____	_____	_____
Marijuana.....	_____	_____	_____	_____
Hallucinogens.....	_____	_____	_____	_____
Blood Pressure Medicine.....	_____	_____	_____	_____
Heart Medicine.....	_____	_____	_____	_____
Birth -.....	_____	_____	_____	_____
Other (please specify) .....	_____	_____	_____	_____

Please list other medications \_\_\_\_\_

Date of last medical examination \_\_\_\_\_ with your Primary Care Physician? \_\_\_\_\_ or Specialist? \_\_\_\_\_

Have you ever had any previous counseling or psychotherapy? Yes / No If yes, when? \_\_\_\_\_

Length? \_\_\_\_\_ Was therapy successful? Please comment: \_\_\_\_\_

\_\_\_\_\_ Have you ever been hospitalized for psychiatric reasons? Yes / No

If yes, when? \_\_\_\_\_ Length of hospital stay? \_\_\_\_\_

Contact in case of emergency: \_\_\_\_\_ Phone number \_\_\_\_\_ Relationship to you: \_\_\_\_\_

In your words, what brings you to therapy today? \_\_\_\_\_

\_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_