PERSONAL INFORMATION SHEET

Patient Name: _____ M / F Date: _____
First Middle Last

Age: _____ DOB: _____ SSN: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Okay to Call: Y / N Okay to Leave Messages: Y / N

Patientôs Cell: _____ Okay to Call: Y / N Okay to Leave Messages: Y / N

Fatherôs Cell: _____ Okay to Call: Y / N Okay to Leave Messages: Y / N

Motherôs Cell: _____ Okay to Call: Y / N Okay to Leave Messages: Y / N

Work Phone: _____ Okay to Call: Y / N Okay to Leave Messages: Y / N

EMERGENCY CONTACT

Emergency Contact: _____ Relation: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Member ID: _____ Group No.: _____

Policy Holder: _____ Relation: _____
First Middle Last

DOB: _____ SSN: _____ Phone: _____

Policy Holderôs Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Full-Time / Part-Time / Retired

Address of Employer: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

SECONDARY INSURANCE INFORMATION

Name of Secondary Insurance Company: _____

Member ID: _____ Group No.: _____

Policy Holder: _____ Relation: _____
First Middle Last

DOB: _____ SSN: _____ Phone: _____

Policy Holderôs Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Full-Time / Part-Time / Retired

Address of Employer: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

PRIMARY CARE PHYSICIAN

Name: _____

Clinic/Hospital: _____

Address: _____

City: _____ State: _____ Phone: _____

REFERRAL SOURCE

Physician Clinic/Hospital Counselor Family Member Friend Internet

Therapist Other: _____ (Please specify below.)

Name: _____

Affiliation: _____

Address: _____

City: _____ State: _____ Phone: _____

REASON FOR SEEKING TREATMENT

Please briefly describe why you or your child are seeking treatment: _____

_____

SYMPTOMS CHECKLIST (From the Patient's Perspective)
Please check all items that currently apply or have applied in the past

Argues, talks back
Body image issues
Bullies, intimidates, provokes others
Cheats
Conflicts with parents
Cruel to animals
Complains/whines
Compulsive behaviors
Please circle: Shopping / Sexual Behaviors / Gambling / Hair Pulling / Other: _____
Cries easily/frequently, feelings easily hurt
Difficulties with parentôs new partner/spouse/new family
Dependent, immature, only younger friends
Divorce/separation of your parents
Divorce/separation from your significant other/spouse
Drug or alcohol use
Eating/food issues
Please circle: Over Eating / Under Eating / Poor Appetite / Vomiting / Other: _____
Fearful, afraid of new situations
Fighting, violent, aggressive, destructive
Fire setting
Friendship issues
Frequent complaints of illness
Grief, loss
Highly immersed in fantasy life, imaginary playmates
Inattentive, distractible, poor concentration, slow to respond
Incontinence, wetting or soiling self at day/nighttime
Interrupts, talks out, yells
Isolates, withdraws
Lack of organization, unprepared
Lacks respect for authority, insults, dares, provokes
Learning disability
Legal difficulties
Please circle: Truancy / Vandalism / Shoplifting / Curfew / Other: _____
Lying
Low frustration tolerance, irritability
Moody
Nail biting, finger sucking, hair chewing, picking at things
Nervous, anxiety, panic attacks
Nicotine use
Present use: _____, Past use: _____
Nightmares
Overactive, restless, hyperactive, fidgety
Oppositional refuses direction, non compliance
Physical or sexual abuse, neglect
Poor sibling relationship(s)
Pouts
Procrastinates, wastes time
Recent move, new school, loss of friends

Rocking, head banging, or other repetitive movements
Runs away
Sad, unhappy, depressed
School problems
Self-harming behaviors
Please circle: Biting / Hitting / Cutting / Burning Self / Other:_____
Sexual issues
Shy, timid
Sleep issues
Please circle: Too Much / Too Little / Frequent Wake-Ups / Other:_____
Suicide talk or attempt
Swearing, foul language, name calling
Temper tantrums, rages
Tics, involuntary movements, noises or word production
Teased, picked on, bullied
Truant, school avoidant
Work avoidance

****Please go back over the Symptom Checklist and mark the three symptoms you are most concerned about, ranking them in order from 1 – 3, with 1 being of highest concern.**

FAMILY & SOCIAL HISTORY (From the Patient's Perspective)

Spouse/Partnerôs Name: _____ Age: _____ Occupation: _____

Motherôs Name: _____ Age: _____ Occupation: _____

Fatherôs Name: _____ Age: _____ Occupation: _____

How many children are in your family of origin: _____ What number are you: _____

Siblingsônames and ages: _____

_____

Do you have any children: Y / N If yes, provide names and ages: _____

_____

Who currently lives in your household: _____

_____

Are your parents separated or divorced: Y / N

If yes, please briefly explain placement arrangement and parentsôlevel of co-parenting with one another: _____

_____

_____

What is your highest grade level completed: _____

How did you do academically in school: _____

What is your current occupation/job: _____

Where do you work: _____ Have you ever been fired: Y / N

Do you have any military history: Y / N

Do you have any concerns relating to their ethnicity or religion: Y / N

If yes, please explain: _____

_____

MEDICAL INFORMATION (From the Patient's Perspective)

Date of last physical: _____ Did you have any significant problems: Y / N

If yes, please identify: _____

_____

Do you take over the counter drugs or vitamins regularly: Y / N

If yes, please list: _____

_____

Please list any <u>current</u> prescribed medication(s):

Medication	Dosage/Frequency	Prescriber	Reason

Please list any <u>previously</u> prescribed medication(s):

Medication	Dosage/Frequency	Prescriber	Reason

If applicable, were there any complications with pregnancy or delivery of your child: Y / N

If yes, please explain: _____

Have you had difficulties with any normal developmental milestones, e.g., physical, psychological, social, intellectual, academic, etc.: Y / N

If yes, please list: _____

_____

Please check any medical issues that apply:

- Allergies
- Anemia
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diarrhea/constipation
- Seizure disorder
- Heart problems
- Headaches/migraines
- Drug allergies
- Head injury
- Vision or hearing problems
- Weight gain or loss
- Frequent illness
- Menstrual irregularities
- Toileting issues
- Other

If you checked any of the above, please explain: _____

_____

PSYCHIATRIC HISTORY (From the Patient's Perspective)

Have you ever received therapy/counseling before: Y / N If yes, where: _____

_____

Have you ever been prescribed psychiatric medication, e.g., antidepressants, antipsychotics, etc.: Y / N

If yes, please list medication and describe the length of time taken and purpose: _____

_____

Have you ever been hospitalized for psychiatric problems: Y / N If yes, please briefly explain: _____

_____

Do you have any personal history of suicide attempts: Y / N If yes, please briefly explain: _____

_____

Has anyone in your family attempted or committed suicide: Y / N If yes, whom: _____

_____

Have any of your family members had a problem(s) with any of the following? If so, what is their relationship to you?

Depression: _____

Anxiety: _____

Eating Disorder(s): _____

Bipolar Disorder/Manic Depression: _____

Obsessive Compulsive Disorder: _____

Substance Abuse: _____

Suicide Attempts: _____

Psychiatric Hospitalizations: _____

Other mental health/psychiatric problems (please specify): _____

CHEMICAL DEPENDENCY/ALCOHOL HISTORY (From the Patient's Perspective)

Do you have a history of alcohol use: Y / N

Do you currently drink: Y / N

If yes, please indicate the amount and frequency.

In a month: _____

In a week: _____

Per day: _____

Do you have a history of drug use: Y / N

Do you currently use any drugs: Y / N

If yes, please indicate the amount and frequency.

In a month: _____

In a week: _____

Per day: _____

Is there anything that was not covered in this form that you feel is important to make your therapist aware of?

_____

_____

_____

Client Signature: _____ Date: _____

Clinician Signature: _____ Date: _____