Client Personal Data

Name _____Age _____ Date_____

Occupation _____ Education _____

If client is a minor, what school does (s)he attend? _____ Grade: _____

Current Living Situation _____

Marital/Partner Status _____How long together?_____

Partner's Name _____ Age _____

Occupation _____ Employer _____

Children	Age	Sex	Siblings	Age	Sex
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____
_____	____	_____	_____	____	_____

What prompted you to call at this time?

Previous Therapist(s) and approximate dates you saw them:

Primary Care Physician: Dr. _____ Phone_____

Psychiatrist: Dr. _____ Phone _____

Other Physician: Dr. _____ Phone _____

Do you currently have a living will or advanced directive? ____Yes ____No

Please mark items in the following list with **Hx** if you have a **history** of these symptoms, and **Pr,** if you are **presently** experiencing them.

____ Anger Problems ____ Head Injury ____ Change in Appetite

Please complete the other side of this form.

____ Computer Addiction	____ Unhappiness	____ Disturbed Body Image
____ Thyroid Problems	____ Digestive Problems	____Memory Problems
____ Dizziness or Fainting	____ Pounding Heart	____ Numbness
____ Headaches	____ Muscle Tension	____ Depression
____ Nightmares/Trouble Sleeping	____ Weight Problems	____ Guilt
____ Heavy Drinking	____ Low Energy	____Racing Thoughts
____ Drug Abuse	____ Excess Energy	____ Binge Eating
____ Suicide Thoughts	____ Panic Easily	____ Blackouts
____ Feelings of Inadequacy	____ Mood Swings	____ Phobia(s)
____ Cold Hands and Feet	____ Anxiety	____ Fatigue
____ Unpleasant Ideas Stay in Head	____ Chest Pain	____ Change in Sex Drive
____Suicide Attempt	____ Purging	____ Other _____

Current or Past Stressors or Problems with:

____ Occupation/Career ____ Marriage/Relationship ____ Legal System ____Loss of Loved One

____ Finances ____Parenting ____Emotional or Verbal Abuse ____ Physical or Sexual Abuse

____ Social Life (Isolation, conflict, etc) ____ Medical/Health Concerns ____Chronic Pain

Current Medications (both prescribed and over-the-counter)

_____ _____ _____

_____ _____ _____

Please list any medication allergies: _____

Hospitalizations: Please list reasons and approximate dates of any hospitalizations.

Any other information that might be helpful to your therapy:

_____