PERSONAL INFORMATION SHEET

Date: ______________ SS#:____________________ DOB:_____________ Age:______

Patient's Name: ______________________________ ______ Female or Male Marital Status:_____________
First Initial Last (circle one)

Address:____
Street/RFD/Apt./Box City, State, Zip

Home Phone:__________________ ok to call☐ Yes☐ No Cell Phone:_______________ok to call☐ Yes☐ No

Work Phone:___________________ok to call☐ Yes ☐ No Can we leave messages: ☐Yes ☐No

Emergency Contact Name & Phone #:____________________________ Relationship to Patient____________

INSURANCE OR PAYMENT INFORMATION (PRIMARY)

Policy Holder:____
Name Address Home Phone

____
Relationship to Patient: Resp. Person DOB Resp. Person SS#

Name of Employer:____________________________________ Work Phone:__________________________

Address of Employer:____

Name of Insurance Co.________________________ Subscriber or ID #:______________________________

Group or DIV #:__________________________

OTHER INSURANCE INFORMATION (SECONDARY)

Name:____
Address Phone

Name of Employer: ____ Phone:__________________________

Name of Insurance Co.______________________________________ Above Named SS#:__________________

Subscriber or ID #:_______________________ Group or DIV #:__________________________

FAMILY DOCTOR

Name: _______________________________ Address: ____

Phone: _____________________________ Clinic/Hospital: ____________________________________

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

____

____

PLEASE CHECK OFF ALL OF THE ITEMS BELOW 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: shopping / sexual behaviors / gambling / hair pulling / other____________________
- ☐ Cries easily/frequently, feelings easily hurt
- ☐ Difficulties with parent's 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
- ☐ 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=truancy, vandalism, shoplifting, curfew
- ☐ Lying
- ☐ Low frustration tolerance, irritability
- ☐ Moody
- ☐ Nail biting, finger sucking, hair chewing, picking at things
- ☐ Nervous, anxiety, panic attacks
- ☐ Nightmares
- ☐ Overactive, restless, hyperactive, fidgety
- ☐ Oppositional refuses direction, non compliance
- ☐ Physical or sexual abuse, neglect
- ☐ Poor sibling relationship(s)
- ☐ Pouts

SYMPTOMS CHECK LIST CONT'D

- ☐ 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-biting, hitting, cutting,burning self
- ☐ Sexual issues
- ☐ Shy, timid
- ☐ Shoplifting
- ☐ Sleep issues-too much, too little, frequent wake-ups
- ☐ 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 write #1, #2, and #3 next to the concerns for which you most want help.**

FAMILY & SOCIAL HISTORY:

(From the patient's perspective)

Mother's Name:_______________________________ Age: ________ Occupation: _________________________

Father's Name:_________________________________ Age: ________ Occupation: _________________________

How many children are in your family of origin:_____________ What number are you?__________

Siblings names and ages:____

____

Do you have any children? If yes, provide names and ages:____

____

Who currently lives in your household? ____

____

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? Yes or No

Do you have any military history? Yes or No

If parents are separated/divorced, please briefly explain placement arrangement and parent's current level of co-parenting with one another:____

____

Do you or does your child have any concerns relating to their ethnicity or religion? Yes or No If Yes, please explain:____

MEDICAL INFORMATION

Who is your Primary Health Care provider (i.e. physician, nurse, OB/GYN)?: ______________________________

Date of last physical:__________________ Did you have any significant problems? Yes / No

If yes, please identify:____

____

Do you take over the counter drugs or vitamins regularly? Yes / No If yes, what are they? _____________
____

Please list any current prescribed medication(s) and the dose(s):____________________________________
____

Prescribed by whom: ____

Please list any previously prescribed medication(s) and the dose(s):__________________________________
____

Prescribed by whom: ____

Were there any complications with pregnancy or delivery of your child? Yes / No / N/A
If yes, please explain:____

Have you or your child had difficulties with any normal developmental milestones? (i.e. walking, talking)
If so, please list:____

____

MEDICAL CONCERNS

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

PSYCHIATRIC HISTORY:
(From the patient's perspective)
Have you ever received therapy/counseling before? Yes / No If yes, where? ___________________________

Have you ever been prescribed psychiatric medication (i.e. antidepressant(s))? Yes / No

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

Have you ever been hospitalized for psychiatric problems? Yes / No

If yes, please describe the reason/situation: ____

Do you have any personal history of suicide attempts? Yes / No

If yes, please describe the situation: ____

____
Has anyone in your family attempted or committed suicide? Yes / No

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?

☐ Yes- Depression: ____

☐ Yes- Anxiety: ____

☐ Yes- Eating Disorder(s): ____

☐ Yes- Bipolar Disorder/Manic-depression: ____

☐ Yes- Obsessive-compulsive disorder: ____

☐ Yes- Alcohol/drug problems: ____

☐ Yes- Suicide attempts: ____

☐ Yes- Psychiatric hospitalizations: ____

☐ Yes- Other mental health/psychiatric problems – please specify: ____

CHEMICAL DEPENDENCY/ALCOHOL HISTORY:

How often and how much do you drink alcoholic beverages?

Never ________________________________

In a week: ______________________________

In a month: _____________________________

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:_______________________________