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INDIVIDUAL PSYCHOTHERAPY · SOLUTION FOCUSED MARITAL THERAPY · BEHAVIORAL MEDICINE

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PERSONAL DATA

A therapist works most effectively when she/he knows as much information as possible about different areas of a client's life. We would like you to fill out as much of this form as possible. Please be candid in your responses, and be assured that this form we be handled in a strictly confidential manner.

DEMOGRAPHIC INFORMATION

1. Date: _____

2. Name: _____ Referred by whom: _____

3. Address: _____ City: _____ State: _____ Zip: _____

4. Home Phone: (____)_____ Work Phone: (___)_____

5. Date of Birth: _____ Age: _____

6. Ethnicity: _____

7. Relationship Status: ☐ Single ☐ Cohabitant ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
   ☐ Other: _____

8. Education: _____

9. Occupation: (present) _____
   (previous) _____

10. Religion: _____

11. Family members currently living in your home:

Name	Relationship	Age	Occupation

12. Other family members (parents, siblings) not listed above:

Name	Relationship	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

13. Medical History:

Present Medication: _____

Serious Illnesses: _____

Disabilities: _____

14. Have you ever sought therapy before?

Name of provider(s): _____

Location: _____

Focus of Therapy: _____

15. Areas of Concern:

15a. For what difficulties or concerns are you seeking therapy?

_____

_____

_____

_____

15b. How much of your concerns are affecting your ability to function effectively?

- ☐ I am immobilized
- ☐ My concerns affect my functioning most of the time
- ☐ My concerns affect my functioning often
- ☐ My concerns affect my functioning from time to time
- ☐ My concerns do not affect my functioning at all

15c. How much trouble are you having coping with your concerns?

- ☐ I find it difficult to cope at all
- ☐ I have difficulty coping most of the time
- ☐ I have difficulty coping often
- ☐ I have difficulty coping from time to time
- ☐ I rarely, if ever, have difficulty coping

16. What lead to your deciding to seek therapy at this particular time?

_____

_____

_____

17. Please check any of the following areas in which you are experiencing difficulty.

☐ Abuse	☐ Eating	☐ Mood Shifts	☐ Self-esteem
☐ Academic	☐ Health	☐ Relationship	☐ Stress
☐ Alcohol	☐ Legal	☐ Sexual	☐ Suicide
☐ Career	☐ Loss	☐ Sexuality	☐ _____
☐ Children	☐ Marital	☐ Sleep	☐ _____
☐ Drugs	☐ Meaning	☐ Social Skills	☐ _____

When you have finished checking the areas of difficulty, place an asterisk (*) beside one, two, or three that are most important.

18. Have you had self-destructive/suicidal thoughts? ☐Yes ☐ No

_____

19. Have you had any unwanted sexual experiences? ☐Yes ☐ No

_____

20. Have you had any significant legal problems? ☐Yes ☐ No

_____

21. Have you had trouble controlling behavior related to alcohol, drugs, food, sex, gambling, smoking, etc.? Please indicate which, if any, apply.

_____

_____

22. Is there anything about your family history (e.g. alcoholism, divorce, mental health) that the therapist might find helpful to know?

_____

_____

_____

23. Please check any of the following feelings that you are struggling with.

☐ Afraid	☐ Betrayed	☐ Hopeless	☐ Panicked
☐ Angry	☐ Confused	☐ Isolated	☐ Self-destructive
☐ Anxious	☐ Depressed	☐ Jealous	☐ Stressed
☐ Apathetic	☐ Guilty	☐ Numb	☐ Worried
☐ Ashamed	☐ Helpless	☐ Overwhelmed	☐ _____

When you have finished checking the relevant feelings above, place an asterisk (*) beside one, two, or three that are most important.

24. How would you like to be different after therapy; that is, what is your goal?

_____

_____

_____

25. What kind of help are you anticipating from a therapist?

_____

_____

26. Support

26a. To what extent do you have an available support network of family and friends with whom you can discuss personal concerns?

☐ I have many individuals available with whom I can talk

☐ I have several individuals available with whom I can talk

☐ I have a few individuals available with whom I can talk

☐ I have no individuals available with whom I can talk

27. Please list activities you engage in for fun and recreation.

_____

_____

This office has a 24-hour cancellation policy. You will be billed for an appointment cancelled without 24-hour prior notice.

_____ _____

Signature of Client Date

_____ _____

Signature of Therapist Date