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ADULT PERSONAL DATA FORM

***Please use the "Additional Information" field at the end of the form if extra space for any response is needed.**

Name: _____ Date:_____

email address: _____ pronouns:_____

Occupation: _____ Employer: _____

Health Insurance Carrier:_____ Policy #: _____

Name of Insured: _____ Date of birth of insured: _____

How did you find out about my practice? _____

Chief Concern

Please describe the main difficulty that has brought you here/reason for seeking therapy:

When did this difficulty begin?

What solutions or efforts have you tried to solve the problems that bring you here?

How effective have these efforts been?

What do you consider to be some of your strengths?

Do you consider yourself to be spiritual or religious?_Yes_ If yes, describe your faith or belief:

What would you like to accomplish during your time in therapy?

Treatment

Have you ever been in counseling/psychotherapy before? ☐Yes ☐ No If yes, please indicate:

When?	*Provider?*	*For what?*	*With what results?*
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever taken, or are you now taking, medications for psychiatric or emotional problems? ☐Yes ☐ No

If yes, please indicate:

When?	*Prescribed by?*	*Name of medication*	*For what?*	*With what results?*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

From whom or where do you get your medical care?

Name	*Specialty*	*Address*	*Phone*	*Date of last visit*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Starting with your childhood and proceeding up to the present, list all major illnesses, important accidents and injuries, hospitalizations, and other medical conditions you have had:

Age	*Illness/Diagnosis*	*Treatment received*	*Result*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other medications you are currently taking:

Name	*Condition*	*Prescribed by*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Alcohol/Drug Use

Average number of alcoholic drinks per week: ☐0 – 2 ☐ 2-5 ☐5-10 ☐More than 10

Use of recreational drugs:

Name of drug	*Frequency*	*Amount per use*
_____	_____	_____
_____	_____	_____

Family

Immediate Family (Spouse/partner, children, etc.) and/or current living situation (roommates, etc.)

Name	*Relationship*	*Age*	*Occupation*	*Currently Living w/ you?*	*Year Deceased*

Family-of-origin (Parents, siblings, etc. – who you grew up with)

Name	*Relationship*	*Age*	*Occupation*	*Currently Living w/ you?*	*Year Deceased*

Emergency Information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Relationship: _____

Address: _____

_____ Phone: _____

Name: _____ Relationship: _____

Address: _____

_____ Phone: _____

Additional Information (if any):