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ADULT PERSONAL DATA FORM

Name: _____ Pronouns: _____ Date:_____

Date of birth: _____ email address: _____

Home (local) address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell: _____

May I leave a message at: ☐ home phone ☐ work phone ☐ cell phone ☐ email

Occupation: _____ Employer: _____

Health Insurance Carrier_____ Policy # _____

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

How did you find out about my practice? _____

*****Please add an additional page, if necessary, to fully complete your responses to the following questions.***

Chief Concern

Please describe the main difficulty that has brought you here: _____

_____

_____

_____

_____

_____

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?_____ 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: _____