PERSONAL INFORMATION FORM – ADULT

Please fill in the information below and bring this form with you to your first session. NOTE: information provided on this form is protected as confidential information.

**CONTACT INFORMATION:**

NAME:

ADDRESS:

MAILING ADDRESS:

Home Phone: May we leave a message?

Cell Phone: May we leave a message?

Home Phone: May we leave a message?

Email Address: May we send email here?

*\*Please note: Email is not considered to be a confidential medium of communication.*

DOB: AGE: GENDER:

MARITAL STATUS:

Never Married Domestic Partnership Married

Separated Divorced Widowed

SPOUSE’S NAME:

EMERGENCY CONTACT: NAME PHONE #

PERSON RESPONSIBLE FOR PAYMENT: DOB:

PERSON WHO REFERRED YOU (if any):

May I send a note of thanks for the referral ( ) Yes ( ) No

**MENTAL HEALTH HISTORY**

•Have you previously received any mental health services (psychotherapy, psychiatric, etc.)? No Yes, previous therapy/practitioner

•Have you ever been and/or are you currently taking prescribed psychiatric medication? No Yes

If yes, please list medication name and dates taken:

•Have you ever contemplated or attempted suicide?

 No Yes

If yes, when?

•Have you ever contemplated or intentionally harmed another person?

 No Yes

If yes, when?

**GENERAL PHYSICAL AND MENTAL HEALTH**

•How would you rate your current physical health? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

•Please list any specific health problems you are currently experiencing:

•Date of last physical

•Family Physician: Phone:

•Physical Disabilities or Limitations:

•Current Medications:

•Injury/Illness/Allergies:

•How would you rate your current sleep habits? (Please circle one.)

Poor Unsatisfactory Satisfactory Good Very Good

•Please list any specific sleep problems you are currently experiencing:

•How many times per week do you generally exercise?

•What types of exercise do you participate in?

•Please list any difficulties you experience with your appetite or eating problems:

•Are you currently experiencing any anxiety, panic attacks or have any phobias? No Yes

If yes, when did you begin experiencing this?

•Are you currently experiencing any chronic pain? No Yes

If yes, please describe:

•Substance use? (Alcohol, Tobacco, Illicit Drugs) No Yes

If yes, what, when, and/or how often?

•Are you currently in a romantic relationship? No Yes If yes, for how long?

•What significant life changes or stressful events have you experienced recently?

**PLEASE RATE THE FOLLOWING 1-5 (1=AWFUL and 5=GREAT):**

Work Family Relationship Peer Relationship\_\_\_\_\_

Romantic Relationship\_\_\_\_\_ Overall Happiness \_\_\_\_\_

**FAMILY HEALTH Please Circle List Family Member**

Alcohol/Substance Abuse Yes No

Anxiety Yes No

Depression Yes No

Domestic Violence Yes No

Eating Disorder Yes No

Obesity Yes No

Obsessive Compulsive Behavior Yes No

Cancer Yes No

High Blood Pressure/Heart Disease Yes No

Bipolar Yes No

**CHECK ANY YOU HAVE EXPERIENCED IN THE PAST WEEK:**

Anger\_\_\_\_ Fear\_\_\_\_ High Energy\_\_\_\_ Sadness\_\_\_\_ Tension \_\_\_\_

Concerns about body \_\_\_\_ Repetitive Thoughts/Behaviors\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING SENTENCES:**

Some of my strengths are

Some of my weaknesses are

Fun for me is

I came here today

What would you like to accomplish in therapy?

**ADDITIONAL INFORMATION**

•Are you currently employed? No Yes If yes, what is your current employment situation:

•Do you enjoy your work? No Yes

•Is there anything stressful about your current work? No Yes If yes, please describe:

•Do you consider yourself to be spiritual or religious? No Yes If yes, describe your faith or belief:

**ACKNOWLEDGEMENT AND AGREEMENT:**

When scheduling an appointment, I agree that I have contracted for that time. I understand that twenty-four (24) hours’ notice is required in order to cancel my appointment (Monday morning appointments must be canceled no later than the previous Friday morning). For the therapist to maintain consistency from one client to another and to maintain flexibility to be able to meet with clients, I understand that THERE WILL BE NO EXCEPTIONS. If I do not cancel an appointment within this time frame, I will be charged for the session **(payment must be made before further sessions will be scheduled).**

Should I decide to access my “out of network” insurance benefits (if available), I understand I am responsible for filing my insurance claims. I understand that I am ultimately responsible for any and all expenses accrued and that payment is due and will be made when services are received. If additional information is needed, I authorize a Tranquil Hearts Counseling Center therapist to release any medical or necessary data to process my insurance claims, and I accept responsibility for charges for this service.

I signify all information regarding the therapist's policies and procedures such as my rights as a client/responsible party, risks and benefits of services, confidentiality, emergencies, payment, and insurance have been discussed with me to my satisfaction. I attest I have received a copy of the Informed Consent, and that I comprehend all information. My signature below acknowledges acceptance of these policies and procedures, and my agreement to enter therapy (or for my dependent to enter into therapy) with a therapist from Tranquil Hearts Counseling Center.

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Client Date

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Therapist Date

I testify that to the best of my knowledge, the information provided above is accurate and complete. I further grant permission for my therapist to consult and share, should she deem it necessary, pertinent information concerning me with other professionals in order to aid my counseling/growth process.

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Client Date