Personal Information Form

www.connectedcounselingfullerton.com

Date: _____

Name _____
Street _____
City, St/ Zip _____
Email _____
Cell #_____
Do you text from this number? Yes No
Other #_____(specify work, home, etc.)
Gender _____Age _____
Date of Birth_____Ethnic Background_____
Relationship Status _____(single, dating, co-habitating, engaged, married, separated, divorced, widowed)
Children (names and ages)_____
With whom do you live _____
Highest level of education _____
Occupation _____
Employer _____
Referred by _____
May I express thanks to him/her for the referral? Yes No
Describe your primary concern(s) and why you decided to seek help at this time

_____

What are your goals, hopes, and expectations regarding psychotherapy?

Have you ever received counseling before? Yes No
If yes, please describe

What was the date of your last physical exam?

Current or significant past illnesses, health conditions

Current medications and reason(s) for taking

Have you ever been prescribed or taken any medication for any mental, emotional, or behavioral problems? Yes No
If yes, please describe

Have you ever been hospitalized for any mental, emotional, or behavioral problems? Yes No
If yes, please describe

Did or does anyone in your family have a mental illness or emotional problems? Yes No
If yes, please describe

Have you experienced any of the following? Please mark P if you experienced it in the past and C if you are currently experiencing it. Please put a * next to those that are significant to you NOW. Please give any further details in the space below.

Difficulty concentrating
Fidgety and restless
Fear or panic
Self-hatred
Underlying sadness
Up and down mood cycles
Excessive worry
Difficulty trusting the motives of others
Depression
Anxiety
Overeating
Under-eating
Purging after eating
Loss of appetite
Excessive exercise
Poor body image
Sleep problems
Loss of interest in work or activities
Social isolation/withdraw
Intrusive thoughts/impulses
Intrusive memories
Anger and hostility
Insecurity
Self-harm/Cutting
Relationship difficulties
Affairs/Infidelity
Pornography
Problematic sexual thoughts/behaviors
Problems related to gender or sexual identity

Difficulties in sexual function/performance
Compulsive behaviors
Hearing or seeing things others do not
Alcohol abuse/misuse
Substance abuse/misuse
Addictions
Distressing or violent fantasies

Further comments:

_____
_____
_____
_____

Have you ever had suicidal thoughts? Yes No
Attempts? Yes No
If yes, please describe and give date/s

_____
_____
_____
_____

Would you like spirituality to be apart of the counseling process? Yes No
If yes, please describe your spirituality

_____
_____
_____
_____

Is there any other information you think is important for your therapist to know?

_____
_____
_____
_____