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PERSONAL DATA SHEET AND QUESTIONNAIRE

Instructions

In order to provide the best care possible, please fill out the following pages as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply, leave them blank. Please initial the bottom of each page and sign the last page of the questionnaire.

Today's Date _____ Date of Birth _____

Full Legal Name _____

Address _____
Street City State Zip

May we send mail to this address? _____Yes _____No

Phone Numbers _____ _____ _____
Home Work Mobile

May we leave detailed messages at these phone numbers?

Home: _____Yes _____No
Work: _____Yes _____No
Mobile: ____Yes _____No

Please note: If you do not authorize leaving a detailed message, messages will be left as follows: "This is Denise Humphrey. Please call me back at 972-239-2490." Messages will not refer to or specify that this is a psychologist's office, although my name might appear on caller ID.

Emergency Contact _____
Name Phone Relation to You

Personal Description

What is your highest education level? _____

What is your race/ethnicity? _____

What is your sexual orientation? _____

Place of employment? _____ Length of time at this job _____

Children _____Yes _____No

If yes, name and ages _____

What is your current relationship status (married, single, divorced, committed relationship)? Circle one.

What are the main reasons you are seeking psychotherapy at this time?

_____
_____
_____

What stressful events have recently occurred?

_____
_____
_____

Check the symptoms and problems areas that you are currently experiencing:

____ Acting Out	____Discrimination	____Procrastination
____Aggression	____ Disorientation	____ Recurring/Unwanted Thoughts
____ Agitation	____ Distractibility	____ Relationship Problems
____ Alcohol Abuse	____ Dizziness	____ Religious/Spiritual Concerns
____ Anger	____ Elevated Mood	____ Self-Esteem/Self-Confidence
____ Anxiety	____ Fatigue/Loss of Energy	____ Self-Harm (e.g. cutting)
____ Appetite Change	____ Feelings of Worthlessness	____ Sexual Assault/Unwanted Sex
____ Avoiding People	____ Hallucinations	____ Sexual Concerns
____ Bingeing/Purging	____ Heart Palpitations	____ Sexual Orientation/ID Issues
____ Body Image	____ Hopelessness	____ Sick Often
____Break-up of a Relationship	____ Impulsivity	____Sleep Problems
____ Chest Pain	____ Internet Use/Abuse	____ Suicidal Thoughts/Feelings
____ Concentration Impairment	____ Irritability	____ Thoughts Disorganized
____ Confusion about Beliefs/Values		____ Time Management
____ Death of Significant Person	____ Memory	____ Trembling
____ Decisions about Career	____ Mood Swings	____ Weight Loss or Gain
____ Depression/Sadness	____ Panic Attacks	____ Withdrawing
____ Diminished Pleasure	____ Phobias/Fears	____ Worrying

When did these symptoms begin? _____

Is there anything that has helped make the symptoms/problems better? _____
_____

Is there anything that has helped make the symptoms/problems worse? _____
_____

How would you like to be different as a result of therapy? _____
_____
_____

What do you like about yourself? What are your strengths?

_____
_____
_____

What do you dislike about yourself? What are your weaknesses?

_____
_____
_____

What are your special interests and hobbies?

_____
_____
_____

Health

Please list any significant health concerns, illnesses, injuries, or surgeries you have experienced.

_____
_____
_____

What medications are you taking and for what purpose?

_____
_____
_____

On average, how much sleep do you get daily? Describe any current or past sleep problems.

_____
_____
_____

Please describe any current or past problems with weight and/or eating:

_____
_____
_____

Please indicate which of the following substances you currently use or have used in the past:

Past	Current	Others: Please List
____	____ Alcohol	_____
____	____ Amphetamines	_____
____	____ Barbiturates	_____
____	____ Cocaine or Crack	
____	____ Heroine	
____	____ LSD/Hallucinogen	
____	____ Marijuana	
____	____ Nicotine	
____	____ Opiates	

Mental Health

Have you or your family members experienced the following, either currently or in the past?

You	Family Member		You	Family Member	
____	____	Separation or Divorce	____	____	Victim of a Crime
____	____	Child Custody Dispute	____	____	Frequent Conflict, Arguing
____	____	Frequent Moves or Relocations	____	____	Name-Calling, Shouting, Insults
____	____	Long Periods of Unemployment	____	____	Punching, Hitting, Slapping
____	____	Death of a Parent Before age 18	____	____	Rape, Sexual Assault
____	____	Violent Temper	____	____	Sexual Abuse
____	____	Arrests or Criminal Record	____	____	Emotional Abuse
____	____	Legal Problems/Lawsuits	____	____	Physical Abuse
____	____	Jail or Prison Term	____	____	Medical Hospitalization
____	____	Involvement with CPS	____	____	Psychiatric Hospitalization
____	____	Suicide Attempt	____	____	Post-Partum Depression
____	____	Pregnancy Loss: Abortion	____	____	Pregnancy Loss: Miscarriage

Have you or any of your family members (including extended family) been diagnosed with and/or treated for any of the following conditions?

You	Family Member		You	Family Member	
____	____	Depression	____	____	Attention Deficit Disorder
____	____	Bipolar Disorder	____	____	Personality Disorder
____	____	Panic Attacks	____	____	Alcohol Abuse/Dependence
____	____	Phobias	____	____	Other Substance Use/Dependence
____	____	Obsessive-Compulsive Disorder	____	____	Schizophrenia/Other Psychosis
____	____	PTSD	____	____	Mental Retardation or Disability
____	____	General Anxiety	____	____	Autism or Asperger's
____	____	Learning Difference/Disability	____	____	Alzheimer's Disorder or Dementia

Please describe any other mental health treatment experiences, including previous counseling, psychotherapy, psychiatric medication, inpatient treatment, and substance-related treatments. Please include when any of these events occurred.

_____
_____
_____

Referral Source

How did you hear about my services (or from whom)?

_____

_____ _____

Client Signature Date

_____

Printed Name