

PERSONAL DATA FORM

2/13/24

Please fill out this form as completely as possible. It will help us get information from you quickly, some of which we will discuss in sessions. Except for the remote possibility of your reporting (1) child abuse, (2) elder abuse, or (3) an intention to harm another person, all your answers are confidential and privileged. If any answers require more space than has been provided, please attach extra sheets. Thank you.

Name: _____

Today's Date: _____

Current Problems

1. Please describe the main difficulties that have brought you to see me.
2. Indicate as best you can any situations, events, or thoughts that seem to trigger these problems or make them worse.
3. What seems to help?

Treatment History

If you have you ever received psychological, psychiatric, or counseling services before please briefly explain the most and least helpful parts.

Current Social Contacts

10. Describe your current and past romantic relationships, including the good parts and the bad parts of the relationships.

11. Your current relationship with your family members, including parents, brothers and sisters, and your children.

General Personal-Social Functioning

15. Please describe your personal appearance as you think others view you.

16. What things, persons, situations, or activities give you real pleasure?

17. What things, persons, situations, or activities cause you discomfort, anxiety, sadness, upset? Please be as specific as possible.

18. How do you cope with being anxious or blue? What can you do to help yourself feel better?

19. What are your personal strengths? What would a person who knows you well say if he or she were to describe your good points? Please be as specific as you can.

20. What are your personal weaknesses? What skills do you lack? What would a person who knows you well say if he or she were to describe your bad points?
21. In general, do you consider yourself assertive enough? That is, do you believe that you adequately express your feelings to others, both positive (e.g., "Thanks for doing that.") and negative (e.g., "I didn't appreciate that comment.")? On the "negative" side, do you feel that you stand up for your rights, express resentment when appropriate, not allow others to take advantage of you, etc? If your answer is no to any of these questions, please explain.
22. Are you having difficulties with sexual matters? If yes, please explain.
23. Do you have difficulty establishing or maintaining friendly and satisfying relationships with others? If yes, please explain.
24. Are you having any difficulties in your job or profession (including working in the home or school)? If yes, please explain.
22. Have you been troubled by headaches, stomachaches, other physical pains or discomfort? If yes, do any of them seem to be caused by thoughts, feelings, or situations (e.g., when being criticized)? Are you being or have you been treated by a physician for any of these problems?
25. What prompted you to decide to seek professional assistance at this particular time?

Family-of-Origin History

Please describe your parents' alcohol/drug use, and mental/emotional problems, and how they got along:

Describe your relationship with each parent and with other adults present:

Abuse History: ___ I was not abused in any way. ___ I was abused.

If you were abused, please indicate the following.

NO YES Physical abuse, such as beatings.

NO YES Sexual abuse, such as touching/molesting, fondling, or intercourse NO

YES Neglect, such as failure to feed, shelter, or protect you

NO YES Emotional or verbal abuse, such as humiliation, etc.

Legal History

List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.

Medical Health History

Please describe your present major physical or health complaints, symptoms, and problems.

Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ☐ Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- ☐ Aggression, violence
- ☐ Alcohol use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness
- ☐ Attention, concentration, distractibility
- ☐ Career concerns, goals, and choices
- ☐ Childhood issues (your own childhood)
- ☐ Children, child management, child care, parenting
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Custody of children
- ☐ Decision making, indecision, mixed feelings, putting off decisions
- ☐ Delusions (false ideas)
- ☐ Dependence
- ☐ Depression, low mood, sadness, crying
- ☐ Divorce, separation
- ☐ Drug use—prescription medications, over-the-counter medications, street drugs
- ☐ Eating problems—overeating, undereating, appetite, vomiting
- ☐ Weight and diet issues
- ☐ Emptiness
- ☐ Failure
- ☐ Fatigue, tiredness, low energy
- ☐ Fears, phobias
- ☐ Financial or money troubles, debt, impulsive spending, low income
- ☐ Friendships
- ☐ Gambling
- ☐ Grieving, mourning, deaths, losses, divorce
- ☐ Guilt
- ☐ Headaches, other kinds of pains
- ☐ Health, illness, medical concerns, physical problems
- ☐ Inferiority feelings
- ☐ Interpersonal conflicts
- ☐ Impulsiveness, loss of control, outbursts
- ☐ Irresponsibility
- ☐ Judgment problems, risk taking
- ☐ Legal matters, charges, suits
- ☐ Loneliness
- ☐ Marital conflict, distance/coldness, infidelity/affairs, remarriage
- ☐ Memory problems

- ☐ Menstrual problems, PMS, menopause
- ☐ Mood swings
- ☐ Motivation, laziness
- ☐ Nervousness, tension
- ☐ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ☐ Oversensitivity to rejection
- ☐ Panic or anxiety attacks
- ☐ Perfectionism
- ☐ Pessimism
- ☐ Procrastination, work inhibitions, laziness
- ☐ Relationship problems
- ☐ School problems (see also "Career concerns . . .")
- ☐ Self-centeredness
- ☐ Self-esteem
- ☐ Self-neglect, poor self-care
- ☐ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ☐ Shyness, oversensitivity to criticism
- ☐ Sleep problems—too much, too little, insomnia, nightmares
- ☐ Smoking and tobacco use
- ☐ Stress, relaxation, stress management, stress disorders, tension
- ☐ Suspiciousness
- ☐ Suicidal thoughts
- ☐ Temper problems, self-control, low frustration tolerance
- ☐ Thought disorganization and confusion
- ☐ Threats, violence
- ☐ Withdrawal, isolating
- ☐ Work problems, employment, workaholism/overworking, can't keep a job

Any other concerns or issues:

Please look back over the concerns you have checked off and star the ones that you need the most help with.

What are your goals for therapy?

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

Life Events Summary: Reflect on your life from birth to present in terms of the highlights, challenges, celebrations, relationships, enduring circumstances, turning points, accomplishments, losses, adventures, and the peaks and valleys that have shaped who you are as a person. You can do this in chart form or narrative form. Summarizing the main aspects of your life history will save us time in therapy.