PERSONAL DATA

This is a <u>confidential record</u> of your personal history. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent to treatment. Please fill out completely.

Date________________________________ **Referred By**____

Client: Name____ Male ❑ Female ❑

Address_____________________________________ City_________________________ Zip Code_____________________

Home Phone(_____)___________________ Cell Phone(____)_________________Work Phone(_____)________________

May we call you at home? Y ❑ N ❑ At Work? Y ❑ N ❑ Highest Grade Completed______________________

Person to notify in case of emergency___________________________________Phone Number________________________

Age__________ Birthdate___________________

Occupation____How Long?___________________

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ ________________________________

Job/Career Satisfaction (low) **1** -------------------------------**5**-------------------------------- **10** (high)

Current Field Address____City_____________________ Zip Code___________

Previous Occupations____

<u>NOTE:</u> *It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.* Would you like spirituality/religious issues to be a part of your therapy? Y ❑ N ❑ Don't Know ❑

Please explain:____

Denomination Affiliation:____

Agency Name:____

Agency Stateside Address: ____

Stateside Home Address (where you are most likely to return for furlough):____

____

Date of next furlough: ____

In your own words, please state the nature of your main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5

Mildly Upsetting Extremely Serious

What goal(s) would you like to accomplish through counseling?

Client Signature ____

How has your cultural adjustment to the field been?

How has your support system been in the field?

FAMILY INFORMATION

Marital status – current: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow/er ❑ Partner ❑ Dating ❑

If married: Age of Spouse: _____ Date of Marriage:_______________

If divorced: Date of marriage to ex-spouse:____________ Date of Divorce:____________

If divorced more than once: Date of previous marriage:___________________Date of Previous Divorce:_______________

If separated: Date of Separation: ___________

If involved with a "significant other": His/her name______________________ His/her occupation____________________

- If you live together: since when?_____________________How long known?______________

Would you describe your intimate relations as satisfactory or unsatisfactory?____

Children: Names and Ages:____

Are your children living with you?____

Other children living with you: Names, Ages, and their Relationship to You:________________________________

____

Other adults living with you:____

____

FAMILY HISTORY

Parents: Father: Age_______ Occupation____

Mother: Age______ Occupation____

Did you grow up with both parents in the home? Y ❑ N ❑

If your parents divorced, what age were you? ________________Custody Arrangement: ________________________________

- Step-father: Age______ Step-mother: Age______

Do you feel closest to your Father? ❑ Mother? ❑ Step Mother ❑ Step Father? ❑ None ❑ Other: _________________

Briefly describe your relationship with your Father____

With your Mother____

Siblings: Brothers' first names & ages____

Sisters' first names & ages____

Other: Please explain if any member of your family has ever suffered from anything which could be described as an "emotional" or "psychological" problem:____

____

Please mention any history of domestic violence, child abuse or sexual abuse in your family:___________________________

____

Please comment on any history of alcohol abuse or illegal drug use in your family:___________________________________

____

ADDITIONAL INFORMATION

Are there any security issues we need to be aware of?

When are you available for a phone consultation? What is the time zone difference?

MEDICAL INFORMATION

Current Weight_________ One Year Ago_________ Maximum_____________ When________________________

Do you exercise regularly? Y ❑ N ❑ How?____

Do you sleep well? Y ❑ N ❑ Amount (hours)___________________________ Easy to get to sleep? Y ❑ N ❑

What recreation do you enjoy?____

Primary Physician____________________________________ City_________________________ Date of last physical____________

The hardest time in your development was: Preschool ❑ Grade School ❑ Jr. High ❑ High School ❑ College ❑ Now ❑

MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑

OTHER CONCERNS

Smoking______________❑_____❑_____❑_____❑

- Packs per week______

Alcohol Intake__________❑_____❑_____❑_____❑

- Frequency (per week):__________________
- How Much? _________________________
- What do you drink? ___________________

Marijuana______________❑_____❑_____❑_____❑

- Amount per week:____________________

Drugs (not medications)__❑_____❑_____❑_____❑

- What? ______________________________
- Frequency:___________________________

MEDICATION HISTORY

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other (please specify)	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

TREATMENT/THERAPY HISTORY

Have you ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Have you ever attempted suicide? Y ❑ N ❑ If YES, when? ____

If YES, method used: ____

Have you ever been hospitalized for psychiatric reasons? Y ❑ N ❑

- If YES, when?_______________________________ Length of hospital stay____________________________