

# PERSONAL INFORMATION SHEET

**Instructions: This confidential information form is for the use of your psychotherapist only. Complete as carefully as possible.**

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State and zip code: \_\_\_\_\_

Age: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

## **Educational Background:**

Highest grade achieved: \_\_\_\_\_ Highest Degree: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work history (include current job first):

\_\_\_\_\_  
\_\_\_\_\_

Referred here by: \_\_\_\_\_ Phone: \_\_\_\_\_

**Marital/Relationship Information:** (If unmarried, check \_\_\_ and go to **X** on next page)

Name of spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different from yours):

\_\_\_\_\_

Spouse's age: \_\_\_\_\_ Date of marriage: \_\_\_\_\_

Your ages when married: Husband's: \_\_\_\_\_ Wife's: \_\_\_\_\_

Spouse's employer: \_\_\_\_\_

Give brief information about any previous marriages:

Date of marriage: \_\_\_\_\_

Reason for end of marriage: \_\_\_\_\_ Date: \_\_\_\_\_

Others? \_\_\_\_\_

**X** If not married, are you currently in a committed relationship? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, partner's name, age, length of relationship:

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Are you living together? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Give brief information regarding any previous relationships:

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**Information about children:**

List children's names and ages (both own children and step-children):

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**Family Information:**

Were you reared by birth parents? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If no, reared by whom?

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Names and ages of parents, brothers, sisters, significant others (dates of death, if applicable):

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Are your parents divorced? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Information:**

Rate your physical health: (check) Very good: \_\_\_\_\_ Good: \_\_\_\_\_ Average: \_\_\_\_\_ Poor: \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_

Your physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you presently taking any medication? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, what?

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**Religious Background:**

Denominational or Faith preference:

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Church/synagogue attendance: Never: \_\_ Seldom: \_\_ Occasionally: \_\_ Frequently: \_\_ Regularly: \_\_

**Therapy Information:**

Please give a brief description of why you are seeking therapy:

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Have you been in therapy before? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, please state for what reason and with whom and when:

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Please note any drug or alcohol abuse by yourself or members of your family. If yes, state if you or family members have received treatment:

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Do you have learning or physical problems that affect attentiveness or ability to learn? If yes, please describe:

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Have you had any serious illnesses, accidents, or traumas? If yes, please describe:

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Have you ever thought about or made a suicide attempt?

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Has anyone in your family ever attempted or succeeded at suicide?

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Have you shown a major change in behavior within the last year? If yes, please describe:

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What would you like to change about yourself or situation as a result of therapy?

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