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Person Data Form-Adult

Background Information

First Name: _______________ Last Name: __________________ Today's Date:__________
Maiden/other: ____________ Date of Birth: ____________ Gender: (circle) M/ F
Social Security #: __________________

Home Address:
Street Address: _______________________ City: _____________________
State:_________- Zip Code: ___________-
Home evening phone # ________________ Cell #: ______________ Work#:______________
E-mail address: ___________________ May I contact you via e-mail?: ___ Yes ____No
May I call you and leave a message on your home number?: ___NO _____Yes
May I call you and leave a message on your work number?: ___NO _____Yes
Please indicate any restrictions: __________________________________

Emergency Contact:
Name: __________________________ Phone #: _________________________
Relationship: ___________________________

Insurance Information:
Do you have insurance?: ____No ___Yes
If yes, please speak to me about how to proceed, and you will need to do all communicating with your insurance company ***. Insurance information and cards needs to be provided at the time of service and retroactive billing will not be allowed. Insurance billing will commence when proper identification and information is provided to the provider****.*
Name of Insurance Company: __________________________ ID #: _________________________
Insurer's Name:___________________ Insurer's DOB:________________
Insurer's group#:________________ Insurer's Social Security for billing:__________________
Insurer's Address: ____
Insurer's Employer:_______________________
Co-payment per session:_____________ Annual Deduction: __________________

Current Employer:
Employer: ____________________ Address: _____________________________
____

Work Phone: ________________________________
Describe your work history and present work situation:
____
____
____
____

Are there any work related problems that brought you here today? ____Yes ______No
If yes, please explain?
____-
____

Marital Status:
_____ Never Married
_____ Married
_____ Separated
_____ Widowed
_____ Divorced
Do you have any children?_____ No _____Yes

Name and Ages of children?

Name: ___________________ Age: _______ Living with you? ____Yes ____No

Name: ___________________ Age:_______ Living with you? ____ Yes ___ No

Name: ___________________ Age:_______ Living with you? ____ Yes ___ No

Name: ___________________ Age:_______ Living with you? ____ Yes ___ No

Present Problems:

Why are you seeking psychotherapy?

____
____
____

What are your goals for therapy?

Are you currently being seen for psychotherapy or by a psychiatrist? ___Yes ______NO
____
____
____

Name and number/address of physician or psychotherapist?

____
____
____

A signed release is required for any communication between myself and outside providers.

Psychotherapy History:

Therapist/Doctor: #	**Dates:**	**Reason for Treatment:**
1.________________________ ______________________________	___________________	
2.________________________ ______________________________	___________________	
3.________________________ ______________________________	___________________	

Please list all medication you currently use (both prescribed and non-prescribed)

Name of medication:	**Dosage:**	**Prescribed by:**

____
____

Have you ever attempted suicide? ___Yes ___No. If yes, please describe the circumstances , how and when?

Has anyone in your family had psychological or psychiatric problems? If so, please explain?
____
____
____

Has anyone in your family had alcohol or drug problems? If yes, please describe?
____
____
____

For women: Pregnant now? _____Yes ________NO Unsure: ________ (Due date: ________)

Medical History-Understanding medical problems may help me plan your treatment.

Do you have any addictions to medications? ____ Yes _____ NO

Please list any history of illness, cancer, hospitalization, injuries and significant medical complications:

Incident/illness/diagnosis: **Date:**
Outcome:

Do any of these medical conditions require ongoing involvement by a physician? If so, name and address of treating physician?

Alcohol/Drug History:

Are you in treatment for alcohol or drug use? _____ Yes ____ NO

How much alcohol do you consume each week? ________________________________

Any drug or alcohol related arrests? Please include dates and charge?

Substance	Ever used?	Used in past yr?	Frequency?	Comments
Caffeine				

Tobacco				
Inhalants/Glue				
Marijuana/hash				
Stimulants/amph-etamines				
Sedatives/				
Xanax/valium Tranquilizers				
LSD/psychedelics PCP (angel dust)				
Cocaine/crack				
Heroin/Opiates				

Social History

Parents or primary caregivers:

Father: Occupation: ____

Brief description of personality:
____
____

What is the major influence your father had on your life?
____
____
____

Mother: Occupation:
____

Brief description of personality?
____
____

Major influence your mother had on your life?
____
____

What 2 or 3 events were important in your childhood and adolescence?
____
____

Who are the most important people in your life now?
____
____
____

Use three words to describe how you see yourself, then 3 words that describe how you think others see you? Self Others

Self	Others
_______________________	_______________________
_______________________	_______________________
_______________________	_______________________

What are your present interests, activities, hobbies?
____
____

Please check off your personal strengths:

_____ likable
_____ appearance
_____ hopeful
_____ emotionally stable
_____ healthy
_____ adaptable
_____ tolerant
_____ resourceful
_____ confident
_____ creative
____sensitive
____intelligent
____witty
____persistent
____loving
____other ________________

List your best qualities and strength from above?
____
____

How did you hear about me? I would like to contact this person to thank them for the referral. If this is ok, please list their name and sign below.

Referred by?
____

Signature: ____

Date: ___________________________