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_____