

## PERSONAL INFORMATION QUESTIONNAIRE

### Identification Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_ SSN: \_\_\_\_\_

Is it O.K. to contact you at home?  
 Yes  
 No

### PRESENT PSYCHOLOGICAL STATUS

Please describe your reason for seeking help	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever seen a counselor or mental health worker before?
	← Why were you seeking help?
<input type="checkbox"/> Yes <input type="checkbox"/> No	← Was the counseling beneficial?
	← Who was the counselor?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever experienced what some people refer to as a “nervous breakdown?”
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been hospitalized for any emotional or psychological difficulties?
	← What was the concern?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does anyone in your family have emotional or psychological problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there anything currently bothering you or causing you to worry?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you having disturbances or difficulty with your sleep?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you experienced any changes in appetite recently?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have there been any sudden changes with your weight?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any health problems (diabetes, heart problems, etc)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you experience times when your heart races and you become short of breath?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you having headaches or migraines?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you experiencing any stomach problems?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any problems with depression?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any suicidal thoughts or attempts? (past or present)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any unwanted thoughts that you can not seem to get rid of?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any problems related to thinking, concentrating, or memory?
<input type="checkbox"/> Short <input type="checkbox"/> Medium <input type="checkbox"/> Long	How would you rate your temper (fuse)?

**FAMILY AND PERSONAL DEMOGRAPHICS**

<b>Spouse/Significant Other</b>	Name: _____ Age: _____	
(If married) Spouse's age at marriage: _____ Occupation: _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has your partner been married previously?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is your partner's occupation a source of conflict in your marriage?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any children?
Name(s): _____		Age(s): _____
_____		_____
_____		_____
_____		_____
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
What kind of relationship do you have with your child(ren)?		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
What kind of relationships do your children have with each other?		
If married, how many years have you been married (current marriage)?		
What was your age when you married (current marriage)?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you been married previously?		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How would you describe your marriage?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have family members that live in the immediate area?		
<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling(s) <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Inlaw(s)		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How well do you like your living arrangements?		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Are you able to keep up with your normal chores and responsibilities?		
Yes		No
Do you find it difficult to remain focused or attentive with tasks?		
What is your occupation?		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Are you satisfied with your career/employment?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is your occupation/employment a source of conflict with your partner?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have any hobbies or other interests?		
← What kind of hobbies?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Lately, have you seemed to lose interest in things that normally bring you pleasure?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have an individual with whom you can share problems or worries (confide)?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you care for any pet(s)?		
← What kind of pet(s)?		

**CHILDHOOD AND FAMILY OF ORIGIN**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have any brothers or sisters?
Name(s):		Age(s):
Occupation(s):		
_____		_____
_____		_____
_____		_____
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
As a child, how did you get along with your brothers/sisters?		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
At present, how do you get along with your brothers/sisters?		
What was your father like?		
_____		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
What kind of relationship did you have with your father?		
What was your mother like?		
_____		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
What kind of relationship did you have with your mother?		
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
What kind of relationship did your parents have with each other?		
As a child, how did you know that your parents loved you?		
_____		
As a child, how did you know that your parents loved each other?		
_____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are your parents divorced?
		← How old were you when this happened?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were you ever abused as a child?
<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
How would you describe your health during childhood?		
<input type="checkbox"/> Nailbiting	<input type="checkbox"/> Bedwetting	Any childhood habits?
<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> Running away	
<input type="checkbox"/> Fears	<input type="checkbox"/> Nightmares	
<input type="checkbox"/> Thumbsucking	<input type="checkbox"/> Other	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did you get into any trouble as a child?
GOOD 7 6 5 4 3 2 1 POOR		How would you characterize your overall childhood?

**EDUCATION AND WORK HISTORY**

<input type="checkbox"/> Did not complete high school <input type="checkbox"/> High school graduate <input type="checkbox"/> College Graduate <input type="checkbox"/> Completed vocational/technical school			Which best describes your educational experience
<input type="checkbox"/> Yes		<input type="checkbox"/> No	Are you currently in school?
			← If yes, where are you enrolled?
<input type="checkbox"/> Yes		<input type="checkbox"/> No	Did you receive any awards or honors in school?
<input type="checkbox"/> Yes		<input type="checkbox"/> No	Were you involved in any extra-curricular activities (band, sports, etc)?
<input type="checkbox"/> Yes		<input type="checkbox"/> No	Do you have any learning problems or complications?
<input type="checkbox"/> Above Average <input type="checkbox"/> Average <input type="checkbox"/> Below Average			What kind of grades did you receive in school?
Good	Fair	Poor	How did you get along with your classmates?
Good	Fair	Poor	How well did you relate with your teachers?
Yes		No	Were you ever in the military?
			← What branch did you serve in?
			← What was your job/specialty?
			← How long did you serve?
Yes		No	Are you currently employed?
Enjoy	It's OK	Dislike	Do you enjoy your present work situation?
Yes		No	Do you have any special job skills or training?
Good	Fair	Poor	How well do you get along with your boss/supervisor?
Good	Fair	Poor	How well do you get along with your co-workers?
Yes		No	Do you have any problems with being late or absent to work?
Yes		No	Have you experienced any accidents or losses while working?
Yes		No	Have you ever been fired from a job before?
Previous jobs you have held?			How long at job
(1) _____			
(2) _____			
Yes		No	Do you have enough money to pay your bills?
Yes		No	Do you have own or have access to a car?

**General Health**

		Who is your family physician?
		When was the last time you saw a physician (approximate)?
Yes	No	Are you currently taking any medications?
		← If yes, please list the medications
Yes	No	Have you ever been prescribed sedatives to help you sleep?
Yes	No	Have you ever been prescribed medication to help with depression?
Yes	No	Are you allergic to any medications?
Yes	No	Do you drink (alcohol) on a regular basis?
Yes	No	Do you smoke?
Yes	No	Have you ever taken/used any illegal drugs? (If yes please indicate)
Cocaine/Crack		Amphetamines (speed)      PCP (Angel dust)
Marijuana		Hallucinogens (LSD, Peyote, "magic mushrooms")
Inhalants (gas, glues, thinners)		Heroin (morphine)
Yes	No	Do you have any sexual concerns?
GOOD 7 6 5 4 3 2 1 POOR		How would you rate your current overall health? (please circle)

**SPIRITUAL INVENTORY**

What relationships have the greatest influence in your life right now?		
<hr/> <hr/>		
Yes	No	Are there any persons from your past that have played a significant part in shaping your view of life? (If yes, please list each)
1)	2)	
Yes	No	Has there been an event in your life (either positive or negative) which was so intense that it permanently affected your outlook on life? (If yes, please describe briefly)
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