

CONTACT INFORMATION FORM

Date_____

Name_____Date of Birth_____age____

Address_____City/Zip_____

Home Phone _____ Work Phone_____

Cell Phone _____ Email_____

Is it okay to leave a message at the above phone numbers if needed?_____

Emergency Contact

Name_____Relationship_____

Home ph._____Work ph._____Cell _____

PERSONAL DATA INVENTORY

Why are you seeking counsel at this time? _____

Marital Status:

(Please check all that apply)

- Single, never married
Engaged ___ months
Married for ___ years
Divorced for ___ years
Separated for ___ years
Divorce in process ___ months
Live-in for ___ years
___ prior marriages (self)
___ prior marriages (partner)

Employment:

(Please check all that apply)

- Employed and satisfied
Employed and dissatisfied
Unemployed
Coworker conflicts
Supervisor conflicts
Unstable work history
Disabled: _____

Financial situation:

(Please check all that apply)

- No current financial problems
Large indebtedness
Poverty or below-poverty income
Impulsive spending
Relationship conflicts over finances

Social support system:

(Please check all that apply)

- Supportive network
Few friends
Substance-use-based friends
No friends
Distant from family
Involved in church fellowship

Military history:

(Please check all that apply)

- Never in military
Served in military-no incident
Served in military with incident

Legal History:

(Please check all that apply)

- No legal problems
Now on parole/probation
Arrest(s) not substance-related
Arrest(s) substance-related
Court ordered this treatment
Other _____
Jail/prison ___ time(s)
Total time served: _____

Family:

Household members other than yourself and spouse (What is your relation to the members, i.e., Biological child, adopted child, foster child, step-child, spouse's child, brother, sister, parent or friend.)

Name _____ Relationship _____ Age _____
Name _____ Relationship _____ Age _____
Name _____ Relationship _____ Age _____

Childhood family experience:

(Please check all that apply)

- Outstanding home environment
Normal home environment
Chaotic home environment
Witnessed physical/verbal/sexual abuse toward others
Experienced physical/verbal/sexual abuse from others

Psychiatric/Health History:

Have you had any prior outpatient psychotherapy? _____

If yes, on ___ occasions. Longest treatment by _____ for ___ sessions, from ___/___ to ___/___.

Have you had any prior inpatient treatment for a psychiatric, emotional, or substance use disorder? _____

If yes, on ___ occasions. Longest treatment at _____ from ___/___ to ___/___

Prior or current psychotropic medication usage? _____

If yes, Medication _____ Dosage _____ Start date _____ End date _____

Date of your last complete physical exam _____

Are you presently being treated for any health problems? _____ If yes, what _____

Please list all medication you are currently taking (give dosage and reason)

Substance Use History: (please check all that apply)

Substance Use Status:

- No history of abuse
- Current Use
- Active abuse
- Past use
- Past abuse

Treatment history:

- Outpatient (date _____)
- Inpatient (date _____)
- 12-step program (date _____)
- Stopped on own (date _____)
- Other _____

Current substances used:

- Alcohol
- Caffeine
- Marijuana
- Nicotine
- Prescription
- Other drugs

Family alcohol/drug abuse history:

- Parent(s)
- Grandparent(s)
- Sibling(s)
- Uncle(s)/Aunt(s)
- Spouse/significant other
- Children
- Other _____

Target Symptoms

Please indicate all symptoms that are experienced by marking the level that best describes their severity. Circle one level for each applicable symptom, and indicate how long the symptom has been present.

	None	Mild	Moderate	Severe	Duration
Depressed Mood					
Fatigue/Low energy					
Hopelessness/Helplessness					
Elevated Mood					
Body Complaints (like headaches)					
Suicidal Ideas					
Weight Gain/Loss					
Anxiety					
Lack of Concentration					
Sleep Disturbance					
Panic					
Phobias					
Obsessions/Compulsions					
Poor Impulse Control (Temper)					
Violence, Anti-social Behavior					
Unusual Energy					
Racing Thoughts					
Disorganized Thinking					
Bizarre Ideation/Impulses					
Homicidal Impulses					
Bingeing/Purging					
Mood Swings					
Irritability					
Delusions					
Hallucinations					
Conduct Problems					
Social isolation					
Worthlessness					
Hyperactivity					
Dissociative states					
Aggressive Behavior					
Alcohol/Chemical Over Use					

Contributing Factors*Please circle how these aspects of your life affect, cause, or relate to any of your symptoms*

Marriage/Relationship	No Effect	Mild	Moderate	Severe	Notes
Family	No Effect	Mild	Moderate	Severe	Notes
Job/School Performance	No Effect	Mild	Moderate	Severe	Notes
Friendships	No Effect	Mild	Moderate	Severe	Notes
Hobbies	No Effect	Mild	Moderate	Severe	Notes
Physical Health	No Effect	Mild	Moderate	Severe	Notes
Sexual Functioning	No Effect	Mild	Moderate	Severe	Notes
Spirituality	No Effect	Mild	Moderate	Severe	Notes

Concerns*Please indicate what concerns you have by circling the severity of each concern listed below.*

Bereavement	No concern	Mild	Moderate	Severe	Comment
Anger with God	No concern	Mild	Moderate	Severe	Comment
Fear	No concern	Mild	Moderate	Severe	Comment
Guilt	No concern	Mild	Moderate	Severe	Comment
Homosexuality	No concern	Mild	Moderate	Severe	Comment
Infidelity of self	No concern	Mild	Moderate	Severe	Comment
Infidelity of spouse	No concern	Mild	Moderate	Severe	Comment
Insecurity	No concern	Mild	Moderate	Severe	Comment
Loss of faith in God	No concern	Mild	Moderate	Severe	Comment
Loss of love	No concern	Mild	Moderate	Severe	Comment
Legal Problems	No concern	Mild	Moderate	Severe	Comment
Relationship with Parents	No concern	Mild	Moderate	Severe	Comment
Relationship with superiors	No concern	Mild	Moderate	Severe	Comment
Religious doubts or fears	No concern	Mild	Moderate	Severe	Comment
Intense anger	No concern	Mild	Moderate	Severe	Comment
Loss of faith in others	No concern	Mild	Moderate	Severe	Comment
Loss of meaning	No concern	Mild	Moderate	Severe	Comment
Nervousness	No concern	Mild	Moderate	Severe	Comment
Eating Habits	No concern	Mild	Moderate	Severe	Comment
Financial problems	No concern	Mild	Moderate	Severe	Comment
Troublesome dreams	No concern	Mild	Moderate	Severe	Comment
Vocational direction	No concern	Mild	Moderate	Severe	Comment
Relationship with children	No concern	Mild	Moderate	Severe	Comment
Despair	No concern	Mild	Moderate	Severe	Comment
Loneliness	No concern	Mild	Moderate	Severe	Comment
Loss of hope	No concern	Mild	Moderate	Severe	Comment
Loss of self-respect	No concern	Mild	Moderate	Severe	Comment
Physical trauma victim	No concern	Mild	Moderate	Severe	Comment
Sexual abuse trauma victim	No concern	Mild	Moderate	Severe	Comment
Physical Trauma Perpetrator	No concern	Mild	Moderate	Severe	Comment
Sexual abuse Perpetrator	No concern	Mild	Moderate	Severe	Comment
Self-Mutilation	No concern	Mild	Moderate	Severe	Comment
Self-doubt	No concern	Mild	Moderate	Severe	Comment

Thank you for your cooperation in completing this form.**Please return to:****Counseling and Education Services****Directions, Inc.**