Personal Data Form

Client Name: _____ Date Of Birth:_____

Parent/Guardian name: _____ Referred By: _____
(If under 18)

Address: _____

Emergency Contact: _____ (relationship)_____(phone)_____

Marital Status: (circle one) Single Married Separated Divorced Widowed

Other immediate family members in the home (list name and age):

1. _____ 2._____
3. _____ 4._____

Have you received previous counseling? ____Yes ____No (if yes, briefly describe)

_____

_____

_____

Please describe briefly reasons for seeking counseling today:

_____

_____

_____

Medical information:

Please describe any medical issues or health issues and any medications you currently take:

_____

_____

_____

_____

_____

1) **Name, address and phone number of physician to be notified in emergency:**

_____

_____

_____

2) **Last physical exam: _____**

3) **Injuries/accidents/hospitalizations/infectious diseases: _____**

_____

4) **Serious medical illness/chronic conditions of other family members**:

(including mental illness)_____

_____

5) **Recent physical complaints: _____**

_____

6) **Medications: _____**

_____

Allergies, idiosyncratic or adverse drug reactions: _____