Mt. Diablo
PSYCHOLOGICAL SERVICES

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Personal Information Form

Today's Date:___________________

The following information is confidential and privileged. Please answer all questions to the best of your knowledge.

Area I

Name: ____________________________________Date of Birth:____________________
Home Address:____
Home Phone: ___________________Mobile Phone: ______________________________
Email:____
Employer: ____________________________Occupation: __________________________
Work Phone: ____
Physician Name: ___________________________Physician Phone: _________________
Emergency Contact Name: _____________________Phone: ______________________
Emergency Contact Email: ____

Area II

Referral Information

Briefly describe the problem(s) you are experiencing and estimate how long you have had the problem(s).

Have you ever had contact with a psychologist, psychiatrist, school counselor or a social services provider for this or other problems? If yes, please provide names, contact information and dates of service.

Have you ever had psychological testing at school or in another setting?
If yes, please indicate where and with whom the testing took place.

Who referred you to MDPS or how did you hear about our program?

<u>Area III</u>

Psychiatric and Medical History

Have you ever been hospitalized for psychiatric reasons?
Please list reasons for hospitalization, dates, hospitals, and diagnosis.

What recommendations were made?

Have you ever thought about suicide? Please describe: Age: __________
Circumstances:

Have you ever attempted suicide? Please describe: Age: ___________
Circumstances:

Are you feeling suicidal right now? Please describe:

Have you ever harmed yourself intentionally, such as cut or burned yourself? Please describe where on the body, severity of self-harm, and whether medical attention was needed.

Do you have a history of medical problems (ie., head injury, seizures, asthma, or other illnesses)?

Please list any medications you are taking currently, including the dosages.

Area IV

Social History

Marital status: ______________________ Partner name:_________________________
Partner age: ______ Partner occupation: ______________________________________

Partner's health or other problems?

Please describe the quality of your relationship.

Please list the names and ages of your children, if any.

With whom do you live? (relationship and ages)

Your education: Highest grade completed: ____________ Degree: ________________

Please describe your occupational history. Do you have any problems at work?

Please describe your support system (family, friends).

Are there significant interpersonal conflicts in your life?

How do you spend your time?

What do you consider your strengths to be?

What aspects about yourself would you like to improve?

Area V

Family of Origin Information

Father's name: ________________________ Living? Y/N Age ____________________
Quality of your relationship (positive/negative?). Please describe:

Mother's name: ____________________________ Living? Y/N Age _______________
Quality of your relationship (positive/negative?). Please describe:

Siblings (age, gender, location):

Do immediate or extended family members have psychological, medical or substance abuse problems now or in the past? Please describe:

Please describe how your family or support system handled stress and how was conflict dealt with. Did people talk about your experience in a way that helped or hurt you?

In looking back, what event(s) seem to have had the greatest effect on you?

Significant experiences at school:

Area VI

Personal Information

Significant sexual history (ie.,significant early relationships, problems related to your sexual history, other than sexual abuse)?

Sexual, physical or emotional abuse? Please describe:

To whom was it reported? By whom?

Alcohol: How often? _______________ Amount? _________ Age you began? _______
Drug use: How often? _______________ Amount? _________ Age you began? _____
Types and drug of choice: ____
Smoking? (packs/day) __________________ Caffeine (cups/day) __________________

Are there any behaviors that you engage in that you believe may be addictive (i.e., you have a hard time stopping after you start, when you aren't engaged in the behavior you think a lot about the next time you might, and/or routinely engage in the behavior as a way of managing stress or unpleasant emotions). Please describe:

______Alcohol ______Prescription or street drugs ______Gambling

______Overeating/restricting/purging ______Sex/pornography ______Video games

Has anyone close to you expressed concern about these behaviors? Please explain:

Do you have any legal issues?