



# ADULT PERSONAL DATA INVENTORY

Please be sure to complete both sides of all sheets.

THANK YOU FOR YOUR COMPREHENSIVE HONESTY IN COMPLETING THESE INITIAL FORMS. ALL THE INFORMATION SHARED BELOW IS COMPLETELY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR PERMISSION, UNLESS ORDERED BY A COURT OF LAW.

## SECTION I. GENERAL INFORMATION

YOUR NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_ MSG OK?  YES  NO

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ BUS./PAGER \_\_\_\_\_ MSG OK?  YES  NO

EMPLOYER \_\_\_\_\_ CELL PHONE \_\_\_\_\_ MSG OK?  YES  NO

OCCUPATION/JOB TITLE \_\_\_\_\_ FAX \_\_\_\_\_

LENGTH OF EMPLOYMENT \_\_\_\_\_ E-MAIL \_\_\_\_\_

MAIDEN NAME (IF ANY) \_\_\_\_\_ MILITARY VETERAN:  YES  NO

SEX  M  F BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

RELIGION \_\_\_\_\_ PLACE OF WORSHIP \_\_\_\_\_

RACIAL/ETHNIC IDENTITY:  AFRICAN-AMERICAN  ASIAN  CAUCASIAN  LATINO  NATIVE AMERICAN

OTHER \_\_\_\_\_

### EDUCATION

LAST YEAR OF SCHOOL COMPLETED: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 OTHER: \_\_\_\_\_

LAST SCHOOL ATTENDED \_\_\_\_\_

DEGREE / SPECIALTY (if any) \_\_\_\_\_

NEAREST RELATIVE OR FRIEND (a person whom we could contact in case of emergency, including a mental health emergency)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRED HERE BY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

MAY WE THANK THE PERSON WHO REFERRED YOU (no confidential information about you will be released)?  YES  NO

WHO IS LIVING IN THE SAME HOME WITH YOU RIGHT NOW? \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

## SECTION II. RELATIONSHIP INFORMATION

CURRENT RELATIONSHIP STATUS:  SINGLE  DATING  LIVING WITH SIGNIFICANT OTHER  ENGAGED  
 MARRIED  SEPARATED  DIVORCED  SPOUSE/PARTNER DECEASED. IF SO, WHEN? \_\_\_\_\_

SPOUSE/PARTNER'S NAME \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_ PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

AGE \_\_\_\_\_ EDUCATION (LAST YR. FINISHED OR DEGREE) \_\_\_\_\_ RELIGION \_\_\_\_\_

CHILDREN: \_\_\_\_\_ LIVING?  YES  NO

HAVE ANY CHILDREN DECEASED? IF SO, WHO AND WHEN: \_\_\_\_\_

HAVE YOU OR A FAMILY MEMBER EVER BEEN IN PRISON? IF SO, WHO AND WHEN? \_\_\_\_\_

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## SECTION III. WHAT BRINGS YOU TO SAMARITAN COUNSELING CENTER?

PLEASE BRIEFLY DESCRIBE YOUR REASON FOR COMING TO SEE A COUNSELOR:

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HOW STRONGLY DO YOU WANT TO CHANGE YOUR PRESENT PROBLEM ON THE SCALE BELOW:

(do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire to change)

HAS THIS PROBLEM AFFECTED YOUR:  RELATIONSHIPS  WORK  MOOD  SEXUALITY  EATING  WORK  
 SLEEPING  SCHOOL  PERFORMANCE  FAMILY  HEALTH  FINANCES  ANXIETY  CONCENTRATION

PLEASE LIST ANY DEATHS, SIGNIFICANT LOSSES, AND/OR TRAUMAS, WITH DATES, AND ANY RECENT MAJOR TRANSITIONS:

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PLEASE PUT A CHECK BY ANYTHING BELOW YOU HAVE EXPERIENCED WITHIN THE PAST THREE MONTHS:

### THOUGHT PROCESSES

- |  |   |
|--|---|
| <input type="checkbox"/> Suicidal thoughts           | <input type="checkbox"/> Hearing voices inside head                 |
| <input type="checkbox"/> Racing thoughts             | <input type="checkbox"/> Experiencing flashbacks                    |
| <input type="checkbox"/> Seeing things others do not | <input type="checkbox"/> Out of body experiences                    |
| <input type="checkbox"/> Always worried              | <input type="checkbox"/> Repetitive obsessive behaviors or thoughts |
| <input type="checkbox"/> Paranoid thoughts           | <input type="checkbox"/> Debilitating fears                         |
| <input type="checkbox"/> Nightmares                  | <input type="checkbox"/> Confused easily                            |
| <input type="checkbox"/> Worried about health        | <input type="checkbox"/> Feel like in a fog                         |
| <input type="checkbox"/> No one understands me       | <input type="checkbox"/> Believe being watched                      |

### FEELINGS

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Feel numb inside                               | <input type="checkbox"/> Feel like hurting someone | <input type="checkbox"/> Feeling tense                     |
| <input type="checkbox"/> Feeling irritable                              | <input type="checkbox"/> Feeling easily hurt       | <input type="checkbox"/> Depressed                         |
| <input type="checkbox"/> Feeling fearful                                | <input type="checkbox"/> Feeling lonely            | <input type="checkbox"/> Feeling guilty                    |
| <input type="checkbox"/> Feeling inferior worthless                     | <input type="checkbox"/> Not enjoying things       | <input type="checkbox"/> Feeling confused                  |
| <input type="checkbox"/> Feeling anxious, nervous                       | <input type="checkbox"/> Grieving                  | <input type="checkbox"/> Feeling hopeless                  |
| <input type="checkbox"/> Feeling angry often                            | <input type="checkbox"/> Feeling panicky           | <input type="checkbox"/> Feeling elated often              |
| <input type="checkbox"/> Feeling like others are conspiring against you | <input type="checkbox"/> Lacking confidence        | <input type="checkbox"/> Experiencing frequent mood shifts |
| <input type="checkbox"/> Feel like smashing things                      | <input type="checkbox"/> Afraid of going out       |  |

### BEHAVIORS

- |   |  |
|---|--|
| <input type="checkbox"/> Explosive anger              | <input type="checkbox"/> Unable to have fun                              |
| <input type="checkbox"/> Withdrawn                    | <input type="checkbox"/> Unable to pray                                  |
| <input type="checkbox"/> Indecisive                   | <input type="checkbox"/> Unable to relax                                 |
| <input type="checkbox"/> More impatient               | <input type="checkbox"/> Repetitive compulsive behaviors                 |
| <input type="checkbox"/> Don't like being alone       | <input type="checkbox"/> Spending a lot of money                         |
| <input type="checkbox"/> Difficulties at work         | <input type="checkbox"/> Strange sexual urges                            |
| <input type="checkbox"/> Impulsive                    | <input type="checkbox"/> Cutting or hurting self                         |
| <input type="checkbox"/> Can't concentrate            | <input type="checkbox"/> Crying spells                                   |
| <input type="checkbox"/> Easily excited               | <input type="checkbox"/> Others have voiced concern about risk behaviors |
| <input type="checkbox"/> Difficulties in relationship |  |
| <input type="checkbox"/> Very restless                |  |
| <input type="checkbox"/> Full of energy               |  |

**PHYSICAL CONDITIONS**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Always tired     | <input type="checkbox"/> Frequent headaches           | <input type="checkbox"/> Lack of energy      |
| <input type="checkbox"/> Poor appetite    | <input type="checkbox"/> Fainting spells              | <input type="checkbox"/> Cold feet and hands |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Muscles twitching or jumping | <input type="checkbox"/> Often feel sick     |
| <input type="checkbox"/> Loss of weight   | <input type="checkbox"/> Chest feels tight            | <input type="checkbox"/> Sexual problems     |
| <input type="checkbox"/> Weight gain      | <input type="checkbox"/> Fast heartbeat               | <input type="checkbox"/> Muscle aches        |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Frequent sweating            | <input type="checkbox"/> Pain down arms      |
| <input type="checkbox"/> Shaky hands      | <input type="checkbox"/> Nausea or vomiting           | <input type="checkbox"/> Joint/back problems |
| <input type="checkbox"/> Stomach trouble  | <input type="checkbox"/> Drugs/Take Sedatives         | <input type="checkbox"/> Weight Gain         |
|   | <input type="checkbox"/> Alcoholism                   | <input type="checkbox"/> Weight Loss         |

HAVE YOU EVER OR ARE YOU CURRENTLY EXPERIENCING ANY FORM OF SEXUAL ABUSE?  YES  NO

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HAVE YOU EVER BEEN OR ARE YOU CURRENTLY IN A DOMESTIC VIOLENCE SITUATION?  YES  NO

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DO YOU FEEL SAFE IN YOUR CURRENT LIVING SITUATION?  YES  NO

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IS THERE ANYTHING ELSE THAT WOULD BE HELPFUL FOR YOUR THERAPIST TO KNOW? \_\_\_\_\_

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WHAT ARE GOALS FOR COUNSELING (*be specific as you can*)? \_\_\_\_\_

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## SECTION IV: FAMILY HISTORY

**FAMILY OF ORIGIN:** (Complete this section about the persons you think of as your:)

### FATHER

### MOTHER

RELATIONSHIP ( <i>circle one</i> )	<input type="checkbox"/> BIRTH <input type="checkbox"/> STEP <input type="checkbox"/> ADOPTIVE <input type="checkbox"/> FOSTER <input type="checkbox"/> OTHER	<input type="checkbox"/> BIRTH <input type="checkbox"/> STEP <input type="checkbox"/> ADOPTIVE <input type="checkbox"/> FOSTER <input type="checkbox"/> OTHER
STILL LIVING?	<input type="checkbox"/> YES <input type="checkbox"/> NO   DATE OF DEATH _____	<input type="checkbox"/> YES <input type="checkbox"/> NO   DATE OF DEATH _____
CURRENT AGE	_____	_____
OCCUPATION	_____	_____
PLACE OF RESIDENCE	_____	_____
EDUCATION COMPLETED	_____	_____
RELIGIOUS PREFERENCE	_____	_____
CHURCH ATTENDANCE PER MONTH ( <i>circle one</i> )	0   1   2   3   4   5+	0   1   2   3   4   5+

ARE YOUR BIRTH PARENTS TOGETHER? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF THEY WERE DIVORCED, YOUR AGE AT THAT TIME _____
ARE YOUR BIRTH PARENTS MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO	AGE OF MOTHER AT BIRTH? _____ FATHER? _____
WOULD YOU RATE YOUR PARENTS' MARRIAGE AS:	<input type="checkbox"/> VERY HAPPY <input type="checkbox"/> HAPPY <input type="checkbox"/> AVERAGE <input type="checkbox"/> UNHAPPY <input type="checkbox"/> VERY UNHAPPY
DID YOU LIVE WITH A FOSTER FAMILY? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS THERE ABUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO
WERE YOU ADOPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	AGE? _____
WOULD YOU RATE YOUR CHILDHOOD LIFE AS:	<input type="checkbox"/> VERY HAPPY <input type="checkbox"/> HAPPY <input type="checkbox"/> AVERAGE <input type="checkbox"/> UNHAPPY <input type="checkbox"/> VERY UNHAPPY
AS A CHILD, DID YOU FEEL CLOSER TO:	<input type="checkbox"/> YOUR FATHER <input type="checkbox"/> YOUR MOTHER <input type="checkbox"/> ANOTHER _____

LIST YOUR CHILDREN IN BIRTH ORDER AND NAME OF THEIR PARENT

NAME	AGE	SEX	LIVING	MARRIED	PARENT
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

ARE THERE ANY SPIRITUAL CONCERNS OF WHICH YOU WOULD LIKE YOUR THERAPIST TO BE AWARE? \_\_\_\_\_

\_\_\_\_\_

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**SECTION V. MEDICAL INFORMATION**

RATE YOUR PHYSICAL HEALTH:  GOOD  AVERAGE  POOR

LIST IMPORTANT PRESENT OR PAST ILLNESSES OR INJURIES: *(Include any hospitalizations and dates)*

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DATE OF LAST MEDICAL EXAMINATION \_\_\_\_\_ PHYSICIAN'S NAME \_\_\_\_\_

YOUR REGULAR (PRIMARY CARE) PHYSICIAN, IF DIFFERENT \_\_\_\_\_

ARE YOU PRESENTLY TAKING PRESCRIPTION MEDICATION?  YES  NO

WHAT AND HOW MUCH?

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MEDICATION GIVEN BY:  PSYCHIATRIST  PERSONAL CARE PHYSICIAN  N/A

DO YOU SMOKE?  YES  NO HOW MUCH? \_\_\_\_\_

DO YOU DRINK ALCOHOL?  YES  NO HOW MUCH? \_\_\_\_\_

DO YOU USE OTHER SUBSTANCES AND IF SO WHAT, HOW MUCH, AND HOW OFTEN? \_\_\_\_\_

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ANY OTHER COMPULSIVE BEHAVIOR? \_\_\_\_\_

HAVE YOU EVER BEEN TREATED OR SEEN BY A PSYCHIATRIST?  YES  NO WHEN? \_\_\_\_\_

NAME: \_\_\_\_\_ APPROX. NUMBER OF SESSIONS \_\_\_\_\_

NAME: \_\_\_\_\_ APPROX. NUMBER OF SESSIONS \_\_\_\_\_

HAVE YOU EVER BEEN TREATED OR SEEN BY ANOTHER COUNSELOR?  YES  NO WHEN? \_\_\_\_\_

NAME: \_\_\_\_\_ APPROX. NUMBER OF SESSIONS \_\_\_\_\_

NAME: \_\_\_\_\_ APPROX. NUMBER OF SESSIONS \_\_\_\_\_

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For Office Use Only:

Client: \_\_\_\_\_

Case #: \_\_\_\_\_

Therapist: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Date of First Session: \_\_\_\_\_

\_\_\_\_\_

Others Present in Session:

\_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Precipitating Problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DSM Axis:

I. \_\_\_\_\_

II. \_\_\_\_\_

III. \_\_\_\_\_

\_\_\_\_\_

IV. \_\_\_\_\_

\_\_\_\_\_

V. GAF Beginning: \_\_\_\_\_ GAF Ending: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Therapist Signature and Credentials

\_\_\_\_\_  
Date

Use the space below for the Genogram and/or Ecomap: