ASCEND
COUNSELING
SERVICES

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PERSONAL INFORMATION FORM

Name____ Date________

Address________________________________, __________________, _____, ___________

Street   Apt #   City   State   ZIP

Email:________________________ Date of Birth_______________ Age______ Sex_____

Telephone: Please indicate which number we may use to leave a message

Y/N Home:________________ Y/N Cell:_________________ Y/N Other:_______________

Emergency Contact: Name____________________Ph#_____________ Relationship to______

Referred by:____

A FAMILY DATA

Briefly describe your biological parents, and your relationship to them:_________________

____

____

____

How did your parents get along with each other?_______________________________________

____

If your parents do not live together please complete the following:

Your age when they Divorced___________ or mother/ father became Deceased_________

Your age(s) when Father remarried ______________Mother remarried__________________

Who raised you as a child: (Please check all that apply)

___Mother ___Father ___Other, as follows___________________________

List your siblings by name, age and gender and full/half/step/adopt (mother or father side).

1)____

2)____

3)____

4)____

5)____

6)____

Use back of paper for more siblings

What is your ethnic background?____

What was your parent's religious background?____

Do you continue to practice this Y/N . If not what is current your religious/spiritual orientation?____

Any special problems or challenges you faced growing up as a child? ____________________

____

Is there any history of mood disorder, abuse or substance abuse with any blood relatives?

____

How did their problem affect family members?____

____

B MARITAL STATUS

If Married: Length of Engagement:___________ Years Married_________________

Spouse's name:_________________ Age____ Occupation___________ Education_______

If Divorced or Widowed:

Ex-spouse Name Dates of ( ) Marriage: ( )Divorce/Death

____

____

Describe your marriage(s): ____

____

____

____

Your Child's Name Age Gender Lives at Home/ Married/ Other Step or Adopted?

1____
2____
3____
4____
5____
6____

C OCCUPATION

Present Employment____

Name of Employer____

Length of Employment______ Income/Salary______________ How do you feel about your job?____

What would you love to do instead?____

Current problems?____

D EDUCATION

Highest grade completed__________ Degree/ Trade in________________________________

How did you do in school?____

How did you feel about school?____

Military?______ Branch__________________ Dates ___________Discharge______________

Do you have any problems with:

Money N/Y ____

Legal N/Y ____

Work N/Y ____

List hobbies/ relaxation:____

E EMOTIONAL/ MEDICAL HISTORY

Please note any that apply now or in the past:

[ ] Compulsions ___________________

[ ] Binging/ Vomiting/ Emotional Eating

[ ] Physical abuse [ ]receive [ ]give

[ ] Emotional abuse [ ]receive [ ]give

[ ] Sexual abuse [ ] receive [ ] give

[ ] Nightmares

[ ] Suicidal thoughts [ ]Suicidal attempt

[ ] Depression, grieving, sadness

[ ] Anxiety attacks, nervousness

[ ] Concentration Difficulties

[ ] Temper outbursts

[ ] Sleep Disturbances

[ ] Frequent tearfulness

[ ] Nervous Tics

[ ] Odd behaviors

[ ] Take too many risks

[ ] Procrastination

[ ] Obsessions

[ ] Social Withdrawal

[ ] Lying

[ ] Phobias

[ ] Chronic Pain in___________________

[ ] Frequent aches/pains in___________

[ ] Accidents/ surgeries______________

[ ] Intestinal problems_______________

[ ] Migraines/ Frequent headaches

[ ] Diabetes

[ ] Accident Prone

[ ] Thyroid Problems

[ ] Asthma

[ ] Allergies_________________

[ ] AIDS/HIV

[ ] STD's

[ ] Dental Problems, teeth grinding

[ ] Menopause

[ ] Heart Problems

[ ] Respiratory Problems

[ ] Sexual Dysfunction

[ ] Bed wetting/ urinary tract problems

[ ] Infertility

[ ] Work too much or can't keep job

[ ] PMS/ menstrual distress

Previous History of counseling, including substance abuse services, self-help groups:

Therapist/Agency/Hospital Date

____

____

Do you now or have you ever had a problem with alcohol or drugs?_____________________

____

Has anyone else ever said you have a problem with alcohol or drugs?___________________

How often do you use the following?

	How long used	Frequency	Amount
Caffeine	_____________________	__________________	______________
Non-prescription drugs	_____________________	__________________	______________
Alcohol	_____________________	__________________	______________
Other	_____________________	___________________	______________
Tobacco	_____________________	___________________	______________

Please list your medications including what they are for (use additional paper if necessary):

____

____

____

____

What else do you think would be helpful for me to know about you and your situation?____

____

____

YOUR PRIMARY PHYSICIAN Name:____

Address: ____City & ZIP_____________________

Phone:______________________ Date last seen:______________

Reason:____

Signature:____ Date: ___________________

Clinician:____ Date: ___________________