PERSONAL INFORMATION SHEET

DATE: _____ SS#: 000-00-__ __ __ __

NAME: _____ AGE: _____ DOB: _____

ADDRESS: _____

MARITAL STATUS: _____ YEARS MARRIED: _____

HOME PHONE: _____ CELL PHONE: _____

OCCUPATION: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

CITY: _____ ZIP CODE: _____

WORK PHONE: _____ Okay to call you at work (Please circle)? YES NO

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

IMMEDIATE FAMILY MEMBERS (Spouse & Children)

NAME:	AGE:	STATE OF HEALTH:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PARENTS: (If deceased, age and cause of death)

NAME:	AGE:	STATE OF HEALTH:
_____	_____	_____
_____	_____	_____

SIBLINGS: (Brothers and Sisters)

NAME:	AGE:	STATE OF HEALTH:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PERSONAL HISTORY

PSYCHOLOGICAL HISTORY: (Indicate Type of Treatment, Individual, marital, family, group, hospitalization)

From	To	Location	Type	Reason
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICAL HISTORY

Present state of physical health: (List any present health problems)

Past medical treatment: (List any operations and/or physical conditions)

I am presently taking the following prescription drugs:

I am presently taking the following over-the-counter drugs:

I use alcohol (State frequency and amount)

I use other substances (marijuana, cocaine, LSD, etc. – state frequency and amount)

PROBLEM INFORMATION

In your own words describe the concerns that currently exist for you and/or members of your family:

How long have these problems existed and when did you first notice them?

What have you tried to do so far to eliminate these problems or concerns?

What are your hopes and expectations regarding how therapy can be of help?

Please feel free to add whatever other information you feel would be helpful.

INSURANCE INFORMATION

Name of Health Insurance: _____

Insurance Identification Number: _____

Insurance Group Number: _____

How are you related to the primary insurance individual? Self Spouse Child Partner

Name of primary Insured: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Bette Hunt. I understand that I am financially responsible for any balance. I also authorize Bette Hunt to release all information necessary to process my claims.

Client/Parent signature: _____ Date: _____

Printed Name Client/Parent: _____ Date: _____

Please Use the following space to share any other information you feel is important for me to know in order to address your problems or concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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If you have any questions about therapy or how therapy works please feel free to write them in the following lines and we will address them together:

_____
_____
_____
_____
_____

THANK YOU FOR COMPLETING THIS FORM. YOU CAN TRUST THAT THIS INFORMATION WILL REMAIN CONFIDENTIAL. YOUR COOPERATION IS GREATLY APPRECIATED.