Confidential Personal History & Information Sheet
For Psychological Services by
Beverly J. Ford, Ph.D., Licensed Clinical Psychologist

Date: _____

Name: _____ SS#: _____ DL#: _____
Address: _____ City: _____ State: ___ Zip: _____
Phone (Home): _____ Business Phone: _____ Cell: _____
Gender: ___F ___M Date of Birth: _____ Age: _____

Relationship Status (more than one answer may apply)

Present marital/relationship status: How long?

___ 1) never married
___ 2) engaged to be married
___ 3) married now for first time
___ 4) married now for the ___ time
___ 5) separated
___ 6) divorced and not remarried
___ 7) widowed and not remarried
8) other (specify) _____

If married/in relationship, are you living together at present? ____ Yes ____ No
If married/in relationship, years with this individual: _____
Assessment of current relationship (if applicable): ____ Good ____ Fair ____ Poor

Number and Ages of Children (if applicable):

Number of son(s) _____ Their ages: ___ ___ ___ ___ ___
Number of daughter(s) _____ Their ages: ___ ___ ___ ___ ___

Are you a blended family? ____ Yes ____ No
Years of education: _____ Currently enrolled in school? ___Yes ___No Major: _____
___ High school grad/GED Favorite Subject: _____ Most Challenging: _____
___ Vocational/Trade School Major: _____
___ College Graduated: ____ Yes ____ No Degree Earned: _____
Other training: _____
Special circumstances (e.g., learning disabilities, gifted): _____
Occupation/Employer: _____ Address: _____
Were you referred by your employer? ___ Yes ___ No If yes, name of supervisor _____
Are you a D.O.T. Driver? ___Yes ___ No Employer: _____
Are you involved in any active legal cases (traffic, civil, criminal)? ____Yes ___No
If yes, explain: _____
Are you receiving counseling services at present? ___ Yes ___ No
If YES, name of counselor and briefly describe what you are working on:
_____
Have you received counseling in the past? ___ Yes ___ No
If YES, name of counselor and briefly describe what you were working on:
_____
How did you hear about my services and/or who referred you? _____

Personal Needs in Therapy

List your greatest strengths:

1) _____
2) _____
3) _____

List your greatest challenges:

1) _____
2) _____
3) _____

List any current or past difficulties at school or work: _____

_____

_____

List your main difficulties at home: _____

_____

_____

Please check behaviors and symptoms that occur :

___ Aggression	___ Elevated mood	___ Phobias/fears
___ Alcohol dependence	___ Fatigue	___ Recurring thoughts
___ Anger	___ Gambling	___ Sexual addiction
___ Antisocial behavior	___ Hallucinations	___ Sexual difficulties
___ Anxiety	___ Heart palpitations	___ Sick often
___ Avoiding people	___ High blood pressure	___ Sleeping problems
___ Chest pain	___ Hopelessness	___ Speech problems
___ Cyber addiction	___ Impulsivity	___ Suicidal thoughts
___ Depression	___ Irritability	___ Thoughts disorganized
___ Disorientation	___ Judgment errors	___ Trembling
___ Distractibility	___ Loneliness	___ Withdrawing
___ Dizziness	___ Memory impairment	___ Worrying
___ Drug dependence	___ Mood shifts	___ Other (specify):
___ Eating disorder	___ Panic attacks	_____

What is (are) your main reason(s) for this visit? _____

_____

How long have these problems persisted? _____

Under what conditions do your problems usually get worse? _____

_____

Under what conditions are your problems usually improved? _____

_____

Any additional information that would assist me in understanding your concerns or problems: _____

_____

What are your goals for therapy? _____

Anything special you would like me to know about you? _____