

Date: \_\_\_\_\_

**ASSOCIATED PSYCHOLOGISTS & COUNSELORS, LLC**

1306 North 13<sup>th</sup> Street; P.O. Box 53

Norfolk, NE 68702-0053

Personal Data Sheet

Client Name \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Marital Status \_\_\_\_\_

Number of Years Married \_\_\_\_\_

Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Birth Date \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Work # \_\_\_\_\_

Spouse's Cell # \_\_\_\_\_

**IF CLIENT IS UNDER AGE 18:**

**Mother's Name** \_\_\_\_\_

**Work #** \_\_\_\_\_

**Father's Name** \_\_\_\_\_

**Work #** \_\_\_\_\_

**Non-custodial parent's address (if applicable):**

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

*Names & Birth Dates of Children (or siblings if client is a child/adolescent):*

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Highest level of education completed by: Self \_\_\_\_\_ Spouse \_\_\_\_\_

Referred to **APC** by: \_\_\_\_\_

Previous Counseling (when & with whom): \_\_\_\_\_

Medication(s) Currently Using \_\_\_\_\_ Physician \_\_\_\_\_

Name & Address of nearest relative or friend NOT living with you:

\_\_\_\_\_  
Telephone \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL PROBLEMS CHECKLIST**

Please check mark all general areas which currently concern you and circle those that are most pressing for you at this time:

- |                    |                            |                            |                           |
|--------------------|----------------------------|----------------------------|---------------------------|
| _____ Shyness      | _____ Parenting            | _____ Depression           | _____ Stress              |
| _____ With Parents | _____ Assertiveness        | _____ Suicide              | _____ Communication       |
| _____ Insomnia     | _____ Guilt                | _____ Separation           | _____ Death               |
| _____ Relaxation   | _____ Divorce Preparation  | _____ Verbal Abuse         | _____ Sexual Abuse/Incest |
| _____ Job Related  | _____ Divorce Adjustment   | _____ Physical Abuse       | _____ School              |
| _____ Legal        | _____ Phobia               | _____ Relationship Problem | _____ Marital             |
| _____ Family       | _____ Marriage Preparation | _____ Blended Family       | _____ Impotence           |
| _____ Dating       | _____ Weight               | _____ Sexual Identity      | _____ Medical Problems    |
| _____ Alcohol Use  | _____ Alcoholism in family | _____ Drug Abuse           | _____ Nervousness/Anxiety |
| _____ Panic        | _____ Anger                | _____ Sexuality            |                           |

Other (explain): \_\_\_\_\_