Date:____________

ASSOCIATED PSYCHOLOGISTS & COUNSELORS, LLC

1306 North 13th Street; Suite 100
Norfolk, NE 68701 - Phone: 403-271-8218 - Fax: 402-371-8259

Personal Data Sheet

Client Name_________________________________
Birth Date______________________Age_________
Address_____________________________________
City____
State__________________________Zip_________
Home Phone #________________________________
Work Phone #________________________________
Cell Phone #________________________________
Email Address:______________________________
Employer____________________________________
Marital Status_______________________________
Number of Years Married______________________
Social Security #____________________________
Guardian (if applicable):______________________

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):
____
____

Individual financially responsible for fee (*please list name, address, and **Social Security Number***):___________
____

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

Highest level of education completed by: Self_________ Spouse______
Referred to **APC** by:____

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):

Date:____________

Please list any previous mental health care providers (if applicable) and approximate dates of service (*e.g., Claire Jones, 12/2009-6/2010*): ____
____
____

What kinds of treatment interventions have been tried in the past? And how effective have these interventions been on a scale from 1-10 (with 10 being the most effective or helpful)? (*e.g., discussing trauma related feelings – 8, behavioral modification strategies – 5*):____
____
____
____

Please describe the client's enjoyable activities:____
____

Please list the client's history of legal involvements, if applicable (*e.g., DUI – 2008*):______________________
____
____

Please describe the client's religious preferences:____

Please describe any current medical conditions or special healthcare needs:____________________________
____
____

Please list medical care providers (a primary care physician, at minimum):_____________________________
____

Please list current medications and prescribed dosages (*e.g., Lexapro – 25 mg*):__________________________
____
____

Please list date of initial prescription or refill for each medication:_________________________________
____
____
____

Please list any over the counter medications being used:____
____
____

Please list any known pre-natal or peri-natal events that may have affected client:_________________________
____

Please list any known allergies or known sensitivities to foods/drugs/other substances:_____________________
____
____