

# PATIENT DATA SHEET®

Please answer ALL questions and FILL IN ALL BLANKS where appropriate. Use separate sheet of paper if necessary.

## BACKGROUND DATA

FULL NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ FULL ADDRESS with ZIP \_\_\_\_\_

AGE \_\_\_\_\_ SEX \_\_\_\_\_ RACE \_\_\_\_\_ OCCUPATION \_\_\_\_\_ RELIGION \_\_\_\_\_ EDUCATION \_\_\_\_\_

HOME PHONE (if calling you at home is OK) \_\_\_\_\_ WORK PHONE (if calling you at work is OK) \_\_\_\_\_

IF YOU ARE ONLINE AND EMAILING YOU IS OK, PLEASE PROVIDE YOUR E-MAIL ADDRESS: \_\_\_\_\_

HOW DID YOU FIND OUT ABOUT OUR SERVICES? \_\_\_\_\_

IF YELLOW PAGES WERE USED TO FIND US, PLEASE CIRCLE the DIRECTORY YOU FOUND US IN: Ameritech McCleod USA Shepherds Guide

YES  NO DO YOU PREFER A COUNSELOR OF A PARTICULAR SEX, RACE, OR RELIGION? IF SO, DESCRIBE: \_\_\_\_\_

YES  NO DO YOU HAVE A PLACE OF WORSHIP? IF SO, WHERE? \_\_\_\_\_

YES  NO HAVE YOU HAD PRIOR COUNSELING EXPERIENCE? IF SO, PLEASE DESCRIBE WHERE, WHEN, AND FOR WHAT PROBLEM: \_\_\_\_\_

YES  NO IMPORTANT! IS COUNSELING TO BE PART OF A LAWSUIT, A DISABILITY CLAIM, OR A DIVORCE PROCEEDING? IF SO, DESCRIBE: \_\_\_\_\_

## MEDICAL DATA

YES  NO DO YOU HAVE ANY MEDICAL PROBLEMS? IF SO, PLEASE DESCRIBE. INCLUDE MEDICATION(S) PRESCRIBED & PHYSICIAN(S): \_\_\_\_\_

YES  NO ARE YOU CURRENTLY TAKING PSYCHIATRIC MEDICATION(S)? IF SO, PLEASE PROVIDE NAME, DOSAGE, & PHYSICIAN: \_\_\_\_\_

YES  NO HAVE YOU BEEN ON PSYCHIATRIC MEDICATION(S) IN THE PAST? IF SO, PROVIDE NAME, DOSAGE, & WHEN: \_\_\_\_\_

YES  NO DO YOU HAVE ANY PRESENT OR PAST PROBLEM WITH YOUR SEXUAL FUNCTIONING?

YES  NO DO YOU HAVE ANY PRESENT OR PAST PROBLEM WITH AN EATING DISORDER? IF SO, PLEASE DESCRIBE: \_\_\_\_\_

YES  NO WOMEN ONLY: HAVE YOU EVER HAD A MISCARRIAGE? IF SO, WHEN? \_\_\_\_\_

IF SO, ARE YOU CURRENTLY EXPERIENCING ANY DISTRESS ABOUT THE EVENT(S)?  YES  NO

YES  NO WOMEN ONLY: HAVE YOU EVER HAD AN ABORTION? IF SO, WHEN? \_\_\_\_\_

IF SO, ARE YOU CURRENTLY EXPERIENCING ANY DISTRESS ABOUT THE EVENT(S)?  YES  NO

## SUBSTANCE USE & ABUSE

YES  NO DO YOU USE TOBACCO? IF SO, DESCRIBE: \_\_\_\_\_

YES  NO DO YOU USE CAFFEINE? IF SO, PLEASE DESCRIBE WHAT YOU DRINK, HOW MUCH, AND HOW OFTEN: \_\_\_\_\_

YES  NO DO YOU USE ALCOHOL? IF SO, DESCRIBE WHAT YOU DRINK, HOW MUCH, AND HOW OFTEN: \_\_\_\_\_

YES  NO HAS YOUR DRINKING HAS EVER BEEN A PROBLEM TO YOU OR ANOTHER PERSON? IS SO, PLEASE DESCRIBE: \_\_\_\_\_

YES  NO HAVE YOU EVER ABUSED ANY DRUGS OR MEDICATION? IF SO, DESCRIBE \_\_\_\_\_

YES  NO HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ABUSE? IF SO, DESCRIBE WHEN, WHERE, and FOR WHAT SUBSTANCE(S):: \_\_\_\_\_

YES  NO HAS ANY FAMILY MEMBER EVER HAD A SUBSTANCE OR ALCOHOL ABUSE PROBLEM? IF SO, DESCRIBE WHO & WHEN: \_\_\_\_\_

## SELF HARM AND ABUSE

YES  NO ARE YOU CURRENTLY EXPERIENCING ANY SUICIDAL THOUGHTS? IF SO, PLEASE DESCRIBE: \_\_\_\_\_

YES  NO HAVE YOU EVER ATTEMPTED SELF-HARM OR SUICIDE? IF SO, WHEN & HOW? \_\_\_\_\_

YES  NO HAVE YOU EVER BEEN PHYSICALLY ABUSED? IF SO, WHEN AND BY WHOM? \_\_\_\_\_

YES  NO HAVE YOU EVER BEEN SEXUALLY ABUSED, or HAD UNWANTED SEXUAL EXPERIENCE(S)? IF SO, DESCRIBE WHEN & BY WHOM? \_\_\_\_\_

YES  NO HAVE YOU EVER BEEN ABUSED VERBALLY OR EMOTIONALLY? IF SO, WHEN & BY WHOM? \_\_\_\_\_

YES  NO HAVE YOU EVER ABUSED SOMEONE PHYSICALLY OR SEXUALLY, OR CAUSED ANOTHER PERSON SERIOUS INJURY OR DEATH? IF SO, PLEASE DESCRIBE: \_\_\_\_\_