PERSONAL DATA SUMMARY

Today's date: _____

TITLE: Ms./Mr./Mrs./Miss/Dr. **Name**: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____

RESIDENCE:
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Calls will be discreet, but please indicate any restrictions: _____
_____

Cell Phone:_____ EMAIL: _____
Age: ____ Sex: ____ Birthplace: _____ Birthdate: _____

EDUCATION:

School and location	Dates	Major	Minors	Degrees and honors

OTHER TRAINING:

Form and place	Dates	Main areas covered

PRESENT POSITION:

Title	Employer (name, address, phone)	Dates	Duties

How long employed here? _____ How long in the same field? _____

PRIOR POSITIONS:

Title	Employer (name, address, phone)	Dates	Duties

MILITARY: Service: _____ Branch: _____ Rank: _____ Dates: _____

Overseas Service? Area: _____ Dates: _____ Combat? Y N Hospitalized? Y N

RELATIONSHIP HISTORY:

Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐

If currently married/partnered, when? _____If separated or divorced, when? _____

If married/partnered more than once, please list (including important nonmarital relationships):

Name of person	Person's age when started	Your age when started	Your age when ended
First _____	_____	_____	_____

(Reasons for ending)_____

_____

Second_____ _____ _____ _____

(Reasons for ending)_____

_____

CHILDREN:

Names	Sex	Age		School and level	With you?

KEY PEOPLE in your life:

	Age	Occupation	Education	Comment (e.g. health, etc.)
Father				
Mother				
Sisters				
Brothers				
Spouse				
Other Important People				

Place "N" beside the name of persons who live at the same place that you do now. Show date of death of any deceased.

CHILDHOOD:

Were your parents ever separated? _____ If so, for how long? _____

How old were you at the time? _____ With whom did you stay? _____

Did you ever live with anyone other than your parents while a child? _____
With whom? _____ How old were you? _____

PHYSICIAN: _____ Address: _____ Zip: _____ Phone: _____

Date last consulted: _____ Last physical: _____

What current medications? _____

Major life illnesses or injuries: _____

NEXT OF KIN: _____ City: _____ State: _____ Zip: _____

RELIGIOUS affiliation: _____ Observant? _____

Name of church or synagogue: _____ Address: _____

Name of priest, minister, or rabbi: _____ Phone: _____

PREVIOUS COUNSELING OR PSYCHOTHERAPY:

Names	Profession	City	Dates	Frequency	Indiv./Gr.

What helped/didn't help regarding the above counseling or psychotherapy?

_____

_____

_____

What are the main concerns that bring you to me?

_____

_____

_____

_____

By whom were you referred? _____ Relation: _____

PSYCHOLOGICAL SYMPTOMS:

How much have the following problems bothered you ***in the past week***? Please circle your answer.	Not at all	A little bit	Somewhat	Very Much	Extremely
SA Scale 6*					
Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
I avoid activities in which I am the center of attention.	0	1	2	3	4
Being embarrassed or looking stupid are my worst fears.	0	1	2	3	4
PD Scale 11*					
It scares me when I feel shaky.	0	1	2	3	4
It scares me when I feel faint.	0	1	2	3	4
It scares me when my heart beats rapidly.	0	1	2	3	4
It scares me when I become short of breath.	0	1	2	3	4
PHO Scale 5					
I avoid (or feel distress in) situations for fear of getting trapped ***or*** that I may have panic and not get help.	0	1	2	3	4
I have phobias (excessive or unreasonable fears of specific situations or objects). Describe specific phobia:	0	1	2	3	4
TRA Scale 9					
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that ***in the past month*** you had any of the following.					
I have had nightmares about the event or thought about it when I did not want to.	True			False	
I tried hard not to think about it or went out of my way to avoid situations that reminded me of the event.	True			False	
I have been constantly on guard, watchful, or easily startled.	True			False	
I have felt numb or detached from others, activities, or my surroundings.	True			False	

Please rate how much you agree with each item. Please circle your answer.	Not at all	A little bit	Somewhat	Very Much	Extremely
OCD Scale 7					
Rate any: I am bothered by ideas, images, or impulses that seem silly, weird, nasty, or horrible and I have trouble getting rid of them; ***or*** I fear doing something impulsively that might cause embarrassment or harm.	0	1	2	3	4
I check things too much (e.g. locks, switches, the stove) ***or*** do calculations repeatedly.	0	1	2	3	4
Rate any: I need to do things in a ritualized way or have things exactly symmetrical or repeat actions until it feels "just right."	0	1	2	3	4
BPD Scale 3					
I engage in behaviors that harm my body (e.g. cutting, hitting or scratching self).	0	1	2	3	4
I have intense feelings of anger that I have difficulty controlling.	0	1	2	3	4
I react impulsively in ways that are either self damaging or damaging of my relationships.	0	1	2	3	4
SOM Scale 9					
I have headaches.	0	1	2	3	4
I have stomach problems.	0	1	2	3	4
I have muscle or joint pains.	0	1	2	3	4
MA Scale 6					
I have gone for days at a time with excessive energy, little or no sleep, and have not felt tired.	0	1	2	3	4
I have had periods or euphoria or irritability, where my thoughts raced and I could not slow my thinking down.	0	1	2	3	4
I have had trouble with grandiose plans, spending sprees, sexual acting out, or other impulsive behavior that seemed right at the time.	0	1	2	3	4

Please rate how much you agree with each item. Please circle your answer.	Not at all	A little bit	Somewhat	Very Much	Extremely
AD Scale 9					
I have been impaired much of my life by difficulty in finishing projects I have started.	0	1	2	3	4
I have been impaired much of my life by a lack of organization.	0	1	2	3	4
I have been impaired much of my life by problems focusing on tasks.	0	1	2	3	4
I have been impaired much of my life by poor time management.	0	1	2	3	4
EDO Scale 3					
I engage in compulsive/binge eating (i.e. eating more than twice what others might eat in a single sitting).	0	1	2	3	4
I use purging, laxatives, or extreme exercise to control my weight.	0	1	2	3	4
I have a history of not eating with excessive weight loss.	0	1	2	3	4
PSY Scale 2					
I believe that others can put thoughts into my head.	0	1	2	3	4
I hear voices talking to me or calling my name when no one is around.	0	1	2	3	4
Sometimes I receive messages from the TV or radio that are specifically directed at me.	0	1	2	3	4
SUI Scale 6					
I have thoughts of suicide.	0	1	2	3	4
I have a specific plan to commit suicide.	0	1	2	3	4
I have a current intent to commit suicide.	0	1	2	3	4
I have guns in my home. □ Yes □ No (check one)					
Prior history of suicide attempts? □ Yes □ No (check one)					
IPA Scale 2					
In your relationship has there been any hitting, insulting, threatening to hurt, or screaming?	0	1	2	3	4
I do not feel safe in my own home.	0	1	2	3	4

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle your answer. **PHQ9***	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling asleep or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television?	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

Look back at the concerns you have rated and circle or check the ones that are the most problematic currently. Please put a numerical ranking next to those that you have circled and rank your top 3 in order of severity. A ranking of 1 is the most severe, a 2 the second most severe, and a 3 is the third most severe. Please write down any expectations (if any) you might have of how therapy can help you address these issues.

_____
_____
_____
_____
_____
_____
_____

Do you have any serious or chronic medical conditions (including past surgeries, head injuries, loss of consciousness, past comas, seizures) If yes, give dates and details _____ ☐ Yes ☐ No

_____
_____
_____

Are you currently taking any medications? Please include over the counter and herbal products. If yes, please list _____ ☐ Yes ☐ No

_____

Alcohol or Other Drug Use:

In the last 12 months, have you abused alcohol or drugs? Yes ☐ No ☐ (please check one)

Do you have a drug or alcohol problem? Yes ☐ No ☐ (please check one)

If you drink alcohol, please indicate current use (one drink equals one shot of liquor, 1 beer, or one glass of wine)
☐ 4 or more drinks per day ☐ 3 – 1 drinks per day ☐ 1 drink per day ☐ less than 5/wk
Last drink (time and amount) _____

Do you use drugs (including marijuana)? Yes ☐ No ☐ (please check one)
If yes, what drugs? _____

How much? _____ How often? _____

Have you ever tried cutting down on your drinking/drug use? Yes ☐ No ☐
Have you ever felt angry/annoyed when asked about your drinking/drug use? Yes ☐ No ☐
Have you ever felt guilty about your drinking drug use? Yes ☐ No ☐
Have you ever been arrested for a DUI? Yes ☐ No ☐

This information will be kept strictly confidential; it will be released only with your written consent. Thank you for your cooperation.

Eric Lee Ryan, Ph.D.
Clinical Psychologist