DEBRA K. KRESCH, LCSW, LMFT, BCD

Individual Psychotherapy • Marriage & Family Counseling • 760 436-6892

ADULT PERSONAL DATA FORM: **All information is held in strict confidence. Your open and honest responses help to facilitate the therapeutic process. Thanks!**

Name_____ Date_____

Birth date_____ Age_____ Birth place_____ ❑ Male ❑ Female

Address_____

City_____ State_____ Zip _____

Home #_____Work #_____Cell _____

Where can I leave a message? ❑ home ❑ work ❑ cell Fax # _____

E-mail address _____ May billing statements be e-mailed? _____

Marital Status: ❑ Never Married ❑ Separated ❑ Domestic Partnership ❑ Divorced ❑ Married ❑ Widowed
Married or in relationship: # of years _____

Religious and/or cultural identification (if any)_____

Employer_____ Occupation(s) _____ Education_____

Referred by_____ Physician_____

Do you give permission to coordinate care with your physician? _____

Emergency Contact: Name_____Phone_____Relationship_____

Current Concern:

_____
_____
_____
_____
_____

Previous Mental Health Treatment, if any:
Year/Treatment (i.e. individual or marital counseling, past medications, hospitalization, drug/alcohol treatment)

_____
_____
_____
_____
_____

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Please list below any medications/vitamins/supplements that you are taking for your mental health:

Medication	**Dosage**	**When started**	**Reason**	**Prescribing M.D.**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Vitamins & Supplements: _____

Medical History: ___ None

___ Head Injury	___ Seizures	___ Thyroid Problems	___ Hypertension
___ Heart Disease	___ Lung Disease	___ Liver Disease	___ Kidney Disease
___ Obesity	___ Fibromyalgia	___ HIV	___ Sexually Transmitted Diseases
___ Hypoglycemia	___ Diabetes	___ Cancer	___ Memory Problems
___ Asthma	___ Arthritis	___ Chronic Pain	___ Headaches
___ MS	___ Meningitis	___ Loss of Consciousness	___ Other _____

Please specify current medical problems _____
Please specify any problems with sleep_____
Please specify any problems with appetite or eating patterns _____
Please specify any current sexual issues _____
Are you able to exercise? ____ frequency/week_____ type_____

Alcohol/Drug/History:

Average days per week of use _____ On typical day, amount of use _____
Have you ever felt you should cut down on your drinking? _____
Have people annoyed you by criticizing your drinking? _____
Have you ever felt bad or guilty about your drinking? _____
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? _____
Do you engage in recreational drug use? ___ If so, frequency _____ type_____
Legal, family, occupation, physical problems due to substance abuse: _____
Past or present alcohol or drug abuse by family member(s)_____
Caffeine use/day (coffee, tea, sodas, chocolate)_____
Nicotine use/day (cigarettes, cigars, tobacco chew)_____

Psychiatric History (i.e. bipolar disorder, depressive disorder, ADHD, OCD, anxiety disorder, eating disorder, schizophrenia, dementia, suicide or attempts - include self, parents, siblings, grandparents, children)

_____
_____
_____
_____
_____

Significant Events (i.e. marriages, divorces, deaths, traumatic events, physical or sexual abuse - include dates)

_____
_____
_____
_____
_____

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Family (include immediate family and people who live with you)

Relationship Name Age Occupation Residence

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pets_____
_____

Symptom Checklist:

Rate current symptoms (0= None, 1=Mild, 2=Moderate, 3=Severe)

___ Aggression/Anger Behavior
___ Alcohol Abuse
___ Anxiety
___ Appetite Changes
___ Anorexic Behavior
___ Bingeing or Purging
___ Bizarre or High Risk Behavior
___ Chest Pains
___ Compulsive Behaviors
___ Computer Addiction
___ Depression
___ Difficulty Concentrating
___ Difficulty Thinking
___ Distractibility
___ Dizziness
___ Drug Abuse
___ Elevated Mood/Mania
___ Fatigue
___ Fears
___ Gambling compulsively
___ Hallucinations or Paranoia
___ Headaches
___ Helplessness
___ Hopelessness
___ Hoarding
___ Hyperactivity
___ Impulsivity
___ Indecisiveness
___ Irritability
___ Loneliness
___ Memory Problems
___ Mood Swings
___ Muscle Tension
___ Obsessive Thoughts
___ Panic Attacks
___ Racing Thoughts
___ Restlessness/On Edge
___ Sexual Addiction
___ Sexual Difficulties
___ Shopping Excessively
___ Sleep Disturbance
___ Social Isolation
___ Suicidal Thoughts
___ Trembling
___ Weight Gain/Less
___ Worrying
___ Worthlessness
_____

Please note main symptom(s) reoccurring over the years, if any: _____

Current stressors (i.e. relationship/family, loss, school, job, unemployment, housing, finances, health, legal)

_____
_____
_____
_____
_____

Current supports, if any (i.e. friend(s) or relative(s) with whom you can confide, support group, religious or spiritual group, volunteer or work activities, recreational or creative outlets)

_____
_____
_____
_____