Bill McClain, LCSW

Individual & Family Counseling

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Personal Information Form

Please state briefly your reasons for seeking services and your goals at this time:

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____

What do you think may get in the way of you resolving your current problems or achieving your goals?

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How would you like things to be different after you have participated in counseling/ consultation?

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How did you hear about my services? ____
May I briefly acknowledge our meeting to any referral source? ___________________
Have you received previous counseling and /or substance abuse treatment: yes _____ no ______

If Yes, Name of therapist/ Agency____
Past Diagnoses? ____
Phone Number ______________________ Month & Years _______________
Name of primary care physician or health practitioner ________________________
Name of psychiatrist or psychiatric nurse practitioner ________________________
Any current medical or mental health conditions being treated? _________________
Any current medications? [if yes, please include daily dose amounts] ______________________________
____

Personal Information pg 2

Ethnic identity & background ________________Current relationship status______________________
My birth parents currently: married/ live together ___separated ___ divorced ____

never lived together ____ one or both deceased ____

Family of Origin
[parents/ step parents, adoptive parents, siblings]

Name	Relationship to you	Age or deceased

Current Family & Household
[partner/spouse, roommates, children]

Name	Relationship to you	Age or deceased

Check all that apply:

History of:	Family of Origin	Current Family & Household
Counseling	________	_______
Alcohol dependence	________	_______
Drug dependence	________	_______
Chronic physical Illness	________	_______
Chronic mental illness	________	_______
Depression	________	_______
Eating Disorders	________	_______
Interpersonal Violence	________	_______
Sex Abuse and/ or Incest	________	_______
Psychiatric hospitalization	________	_______
Suicide Attempts/Completion	________	_______

I use alcohol: never__ less than once/ week__ more than once /week___ daily___
I use drugs: never__ less than once/ week__ more than once /week___ daily___
I use tobacco: never__ less than once/ week__ more than once /week___ daily___
I have experienced an unwanted sexual experience: recently___ in the past___
sexual assault___ date rape__ rape__ incest___
My sleep is: _________ hours a night / Frequent waking? / Difficulty falling asleep? ___ Staying asleep?___
I am dissatisfied with my personal appearance _____
I have felt like or tried to hurt myself in the past______ and/ or _________currently
I have suffered a significant loss death ______relationship ending ______ other________________
I have experienced:
___ medical complications at birth
___ serious head injury (or knocked out)
___ past learning disability or attention deficit/ hyperactivity disorder
___ permanent disability (if checked, please describe ________________)
___ legal difficulties (if checked, please describe ________________)

Personal Information pg 3: Symptom Checklist

Please mark the level that best describes your experience. If the item does not apply to you, please leave blank.

Severity
- Past: Interfered with daily living in the past
- Mild: Occurs occasionally, no or mild interference with daily living
- Medium: Occurs more often than not, moderate interference with daily living
- Severe: Occurs daily, extreme interference with daily living

Severity	Past	Mild	Medium	Severe	Severity	Past	Mild	Medium	Severe
Depressed mood most of the day, nearly every day					Fear of losing control				
Loss of interest or pleasure					Fear the worst happening				
Significant weight change					Feeling dizzy or faint				
Sleeping too much					Fear of dying				
Loss of energy					Sensations of shortness of breath				
Fatigue					Trembling or shaking				
Sleeping too little					Chest pain or discomfort				
Feeling worthless					Feelings of choking				
Difficulty concentrating or indecisiveness					Panic Attacks				
Feeling slowed down									
Recurrent thoughts of death					Having recurrent/persistent thoughts or worries				
Thoughts of suicide					Doing repetitive behaviors when nervous				
Feelings of guilt					Feeling excess anxiety about being in certain situations				
Lack of motivation					Difficulty asserting myself				
Feeling like a failure									
Feeling unattractive					Irritability				
Feeling pessimistic about the future					Restlessness				
Self-blame or criticism					Muscle Tension				
Loneliness					Difficulty concentrating or mind going blank				
Easily distracted					History of sexual abuse				
Feeling extra high or good					History of physical abuse				
Increases in goal directed activity					History of emotional abuse				
No need for sleep for 2 days or more					Experience of traumatic event				
Behavior that has caused problems					Recurrent troubling memories				
Increased involvement in pleasurable activities with negative consequences					Recurrent distressing dreams				
Feeling agitated					Exaggerated response to being startled				
Thoughts racing					Outbursts of anger				
Poor judgment					Feeling hypervigilant				
					Fear of assault by strangers				
Thoughts of harming others					Flashbacks				
Acts of violent behavior									
Hearing things that aren't there					Lesbian, gay, bisexual or transsexual concerns				
Seeing things that aren't there					Problems in romantic relationships				
Feeling like I am being punished					Lack of interest in sex				
Feeling like others are out to get me					Harassment related to my gender				
Difficulty getting along with others					Sexual concerns				
Destroying property					Difficulty expressing emotions				
					Memory problems				
					Headaches				
Drug abuse or dependence					Poor appetite				
Alcohol abuse or dependence					Overeating				
Falling asleep from alcohol or drug use					Limiting food intake, vomiting, laxatives or over exercise to control weight				
Treatment for drug or alcohol use					Weight change of five pounds or more in last month				
Drug or alcohol related legal issues					Difficulty parenting				
Withdrawal symptoms from drugs or alcohol					Other concerns? Please list~				
Increased tolerance to drugs or alcohol									