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|  | **CHESHIRE PSYCHOLOGICAL AND SPIRITUAL HEALTH SERVICES**  |  | Deborah C. Cheshire, Psy.D372 West Street, Ste. 200 Keene, NH 03431802-451-0241 |  |
| **Personal Information Form** |  |
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| ***INSTRUCTIONS:*** *This confidential, 2-sided form begins the dialogue with your therapist. Please fill in much information as you are comfortable completing.* |
| **PERSONAL INFORMATION**  | Today’s Date |  |
| Your Name: |  |
| Address: |  | City: |  | State: |  | Zip: |  |
| Phones: Home: |  | Work: |  | Cell: |  |
| Email Address: |  |
| Date of Birth: |  | Age: |   | Gender / Sex: |  |
| Relationship Status: | [ ]  Single? [ ]  Married? [ ]  Partnered / Living together? [ ]  Separated / Living apart? [ ]  Divorced? [ ]  Widowed? |
| Highest level of education completed: |  | Military History (Branch & Years of Service): | [ ]  Check if none |
| Occupation: |  | Employer: |  |
| List of Current Legal Issues: |  |
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| **HEALTH INSURANCE INFORMATION *If you have no health insurance, check here****[ ]*  |
| Medicaid ID No: |  | Medicare ID No: |  |
| Name of Insurance: |  | ID No.: |  | Group No.: |  |
| Name of Subscriber: |  | Subscriber’s Social Security Number: |  |
| Subscriber’s Employer: |  | Client’s Relationship to the subscriber: |  |
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| **HEALTH INFORMATION** |
| Your Primary Care Physician: |  | Location: |  | Phone No.: |  |
| Other Physicians/Providers:  |  |
| How do you rate your overall physical health and fitness? [ ]  Very good [ ]  Good [ ]  Average [ ]  Poor / Declining |
| Have you seen a physician in the past 6 months? [ ]  Yes [ ]  No If yes, specify the reasons: |  |
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| What medicines or supplements do you take regularly or occasionally (including dosages)? |  |
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| Have you had any current or past experience with the following: |
|  | Yes | No |  | Yes | No |  | Yes | No |
| Eating problems? | [ ]  | [ ]  | Developmental disability? | [ ]  | [ ]  | Surgeries? | [ ]  | [ ]  |
| Weight gain or loss? | [ ]  | [ ]  | Cancer? | [ ]  | [ ]  | Chronic Illness? | [ ]  | [ ]  |
| Sleeping difficulties? | [ ]  | [ ]  | Heart disease / high blood pressure? | [ ]  | [ ]  | Remorse or guilt after drinking or using drugs? | [ ]  | [ ]  |
| Sexual concerns? | [ ]  | [ ]  | Previous counseling? | [ ]  | [ ]  | Attempts to reduce your alcohol or drug use? | [ ]  | [ ]  |
| Low energy? | [ ]  | [ ]  | Prescribed psychiatric medicine? | [ ]  | [ ]  | Have others criticized your alcohol or drug use? | [ ]  | [ ]  |
| Injuries or accidents? | [ ]  | [ ]  | Psychiatric hospitalization?  | [ ]  | [ ]  | Have you ever faced DWI / DUI or drug charges? | [ ]  | [ ]  |
| Other health issues?  | [ ]  | [ ]  | Specify: |  |
| For each ‘yes,’ please give details: |  |
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| Has any member of your family experienced mental illness or required psychiatric medications or hospitalization? [ ]  Yes [ ]  No If yes, please describe: |
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| **RELIGIOUS OR SPIRITUAL INFORMATION** |
| Do you follow particular religious or spiritual traditions? (Please specify) |  |
| What were your childhood religious or spiritual practices? |  |
| How important is spirituality in your life? |  |
| **HOUSEHOLD & FAMILY INFORMATION** |
| Name of spouse / partner: |  | Date of birth: |  | Age: |  |
| If married, date of marriage: |  | How long living together? |  | How long acquainted? |  |
| *Previous marriages & significant relationships:* |
| Name of previous spouse or partner | Date of marriage / living together | Date of separation / death | Date of divorce |
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| *Your children:* |
| Name of your child | Sex | Age | Date of birth | Other parent | Lives with |
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| Who else lives in your home? |  |
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| **INFORMATION ABOUT YOUR CHILDHOOD & FAMILY** |
| Names of your parents / step-parents: | Divorced / separated? (If yes, when?) | Still living? (If no, date of death?) | Helped raise you? |
| Your mother: | [ ]  Yes [ ]  No | [ ]  Yes [ ] No | [ ]  Yes [ ]  No |
| Your father: | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Step-parent: | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Step-parent: | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Other (describe): | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| *List brothers & sisters in birth order, INCLUDING YOURSELF* |
| Names (Indicate if step-, half-, adopted or foster sibling.) | Sex | Age | City / state wherecurrently residing | Marital / relationship history | Comments |
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| How would you rate your childhood life? | [ ]  very happy | [ ]  happy | [ ]  average  | [ ]  unhappy  | [ ]  very unhappy |
| As a child, whom did you feel close to?  | [ ]  mother | [ ]  father | [ ]  step-parent | [ ]  grandmother | [ ]  grandfather | [ ]  other  |  |
| Comments on your childhood: |  |
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| **OTHER INFORMATION** |
| Reasons for coming to therapy: |  |
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| Please list significant events, concerns, or anything else that you may want us to know: |  |
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