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|  | | | | | **CHESHIRE PSYCHOLOGICAL AND SPIRITUAL HEALTH SERVICES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Deborah C. Cheshire, Psy.D  372 West Street, Ste. 200  Keene, NH 03431  802-451-0241 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| **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 where currently 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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