ADULT PERSONAL DATA INVENTORY

Please be sure to complete both sides of all sheets to the best of your ability.

Thank you for your comprehensive honesty in completing these initial client forms. All the information shared below is completely confidential and will not be released to anyone without your permission, unless ordered by a court of law. If you have any questions, please contact: CENTER[ED] ON WELLNESS, 1850 Colfax Avenue, Benton Harbor, MI 49022, P: 269.926.6199, F: 269.926.6780, E: info@centeredonwellness.info, W: centeredonwellness.info

SECTION I. GENERAL INFORMATION

YOUR NAME _____ DATE _____

ADDRESS _____ HOME PHONE _____ MSG OK? ☐ YES ☐ NO

CITY _____ STATE _____ ZIP _____ BUS./PAGER _____ MSG OK? ☐ YES ☐ NO

EMPLOYER _____ CELL PHONE _____ MSG OK? ☐ YES ☐ NO

OCCUPATION/JOB TITLE _____ FAX _____

LENGTH OF EMPLOYMENT _____ E-MAIL _____

MAIDEN NAME (IF ANY) _____ MILITARY VETERAN: ☐ YES ☐ NO

SEX ☐ M ☐ F BIRTH DATE _____/_____/_____ AGE _____ PLACE OF BIRTH _____

RELIGION _____ PLACE OF WORSHIP _____

RACIAL/ETHNIC IDENTITY: ☐ AFRICAN-AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ LATINO ☐ NATIVE AMERICAN

☐ OTHER _____

EDUCATION

LAST YEAR OF SCHOOL COMPLETED: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 OTHER: _____

LAST SCHOOL ATTENDED _____

DEGREE / SPECIALTY (*if any*) _____

NEAREST RELATIVE OR FRIEND (*a person whom we could contact in case of emergency, including a mental health emergency*)

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ PHONE _____

REFERRED HERE BY _____ RELATIONSHIP _____

MAY WE THANK THE PERSON WHO REFERRED YOU *(no confidential information about you will be released)*? ☐ YES ☐ NO

WHO IS LIVING IN THE SAME HOME WITH YOU RIGHT NOW? _____

_____

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_____

_____

SECTION II. RELATIONSHIP INFORMATION

CURRENT RELATIONSHIP STATUS: □ SINGLE □ DATING □ LIVING WITH SIGNIFICANT OTHER □ ENGAGED
□ MARRIED □ SEPARATED □ DIVORCED □ SPOUSE/PARTNER DECEASED. IF SO, WHEN? _____

SPOUSE/PARTNER'S NAME _____

ADDRESS (IF DIFFERENT) _____ PHONE _____

OCCUPATION _____ EMPLOYER _____ BUSINESS PHONE _____

AGE _____ EDUCATION (LAST YR. FINISHED OR DEGREE) _____ RELIGION _____

CHILDREN: _____ LIVING? □ YES □ NO

HAVE ANY CHILDREN DECEASED? IF SO, WHO AND WHEN: _____

HAVE YOU OR A FAMILY MEMBER EVER BEEN IN PRISON? IF SO, WHO AND WHEN? _____

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SECTION III. WHAT BRINGS YOU TO CENTER[ED] ON WELLNESS?

PLEASE BRIEFLY DESCRIBE YOUR REASON FOR COMING TO SEE A COUNSELOR:

_____

_____

HOW STRONGLY DO YOU WANT TO CHANGE YOUR PRESENT PROBLEM ON THE SCALE BELOW:

(do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire to change)

HAS THIS PROBLEM AFFECTED YOUR: □ RELATIONSHIPS □ WORK □ MOOD □ SEXUALITY □ EATING □ WORK

□ SLEEPING □ SCHOOL □ PERFORMANCE □ FAMILY □ HEALTH □ FINANCES □ ANXIETY □ CONCENTRATION

PLEASE LIST ANY DEATHS, SIGNIFICANT LOSSES, AND/OR TRAUMAS, WITH DATES, AND ANY RECENT MAJOR TRANSITIONS:

_____

_____

PLEASE PUT A CHECK BY ANYTHING BELOW YOU HAVE EXPERIENCED WITHIN THE PAST THREE MONTHS:

THOUGHT PROCESSES

- ☐ Suicidal thoughts
- ☐ Racing thoughts
- ☐ Seeing things others do not
- ☐ Always worried
- ☐ Paranoid thoughts
- ☐ Nightmares
- ☐ Worried about health
- ☐ No one understands me
- ☐ Hearing voices inside head
- ☐ Experiencing flashbacks
- ☐ Out of body experiences
- ☐ Repetitive obsessive behaviors or thoughts
- ☐ Debilitating fears
- ☐ Confused easily
- ☐ Feel like in a fog
- ☐ Believe being watched

FEELINGS

- ☐ Feel numb inside
- ☐ Feeling irritable
- ☐ Feeling fearful
- ☐ Feeling inferior worthless
- ☐ Feeling anxious, nervous
- ☐ Feeling angry often
- ☐ Feeling like others are conspiring against you
- ☐ Feel like smashing things
- ☐ Feel like hurting someone
- ☐ Feeling easily hurt
- ☐ Feeling lonely
- ☐ Not enjoying things
- ☐ Grieving
- ☐ Feeling panicky
- ☐ Lacking confidence
- ☐ Afraid of going out
- ☐ Feeling tense
- ☐ Depressed
- ☐ Feeling guilty
- ☐ Feeling confused
- ☐ Feeling hopeless
- ☐ Feeling elated often
- ☐ Experiencing frequent mood shifts

BEHAVIORS

- ☐ Explosive anger
- ☐ Withdrawn
- ☐ Indecisive
- ☐ More impatient
- ☐ Don't like being alone
- ☐ Difficulties at work
- ☐ Impulsive
- ☐ Can't concentrate
- ☐ Easily excited
- ☐ Difficulties in relationship
- ☐ Very restless
- ☐ Full of energy
- ☐ Unable to have fun
- ☐ Unable to pray
- ☐ Unable to relax
- ☐ Repetitive compulsive behaviors
- ☐ Spending a lot of money
- ☐ Strange sexual urges
- ☐ Cutting or hurting self
- ☐ Crying spells
- ☐ Others have voiced concern about risk behaviors

PHYSICAL CONDITIONS

□ Always tired	□ Frequent headaches	□ Lack of energy
□ Poor appetite	□ Fainting spells	□ Cold feet and hands
□ Trouble sleeping	□ Muscles twitching or jumping	□ Often feel sick
□ Loss of weight	□ Chest feels tight	□ Sexual problems
□ Weight gain	□ Fast heartbeat	□ Muscle aches
□ Dizziness	□ Frequent sweating	□ Pain down arms
□ Shaky hands	□ Nausea or vomiting	□ Joint/back problems
□ Stomach trouble	□ Drugs/Take Sedatives	□ Weight Gain
	□ Alcoholism	□ Weight Loss

HAVE YOU EVER OR ARE YOU CURRENTLY EXPERIENCING ANY FORM OF SEXUAL ABUSE? □ YES □ NO

_____

_____

HAVE YOU EVER BEEN OR ARE YOU CURRENTLY IN A DOMESTIC VIOLENCE SITUATION? □ YES □ NO

_____

_____

DO YOU FEEL SAFE IN YOUR CURRENT LIVING SITUATION? □ YES □ NO

_____

_____

IS THERE ANYTHING ELSE THAT WOULD BE HELPFUL FOR YOUR THERAPIST TO KNOW? _____

_____

_____

WHAT ARE GOALS FOR COUNSELING (*be specific as you can*)? _____

_____

_____

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CENTERed on WELLNESS .info

SECTION IV. FAMILY HISTORY

FAMILY OF ORIGIN: (*Complete this section about the persons you think of as your parents.)*

	FATHER	**MOTHER**
RELATIONSHIP *(check one)*	☐ BIRTH ☐ STEP ☐ ADOPTIVE ☐ FOSTER ☐ OTHER	☐ BIRTH ☐ STEP ☐ ADOPTIVE ☐ FOSTER ☐ OTHER
STILL LIVING?	☐ YES ☐ NO DATE OF DEATH _____	☐ YES ☐ NO DATE OF DEATH _____
CURRENT AGE	_____	_____
OCCUPATION	_____	_____
PLACE OF RESIDENCE	_____	_____
EDUCATION COMPLETED	_____	_____
RELIGIOUS PREFERENCE	_____	_____
CHURCH ATTENDANCE PER MONTH *(circle one)*	0 1 2 3 4 5+	0 1 2 3 4 5+

ARE YOUR BIRTH PARENTS TOGETHER? ☐ YES ☐ NO IF THEY WERE DIVORCED, YOUR AGE AT THAT TIME _____

ARE YOUR BIRTH PARENTS MARRIED? ☐ YES ☐ NO AGE OF MOTHER AT BIRTH? _____ FATHER? _____

WOULD YOU RATE YOUR PARENTS' MARRIAGE AS: ☐ VERY HAPPY ☐ HAPPY ☐ AVERAGE ☐ UNHAPPY ☐ VERY UNHAPPY

DID YOU LIVE WITH A FOSTER FAMILY? ☐ YES ☐ NO WAS THERE ABUSE? ☐ YES ☐ NO

WERE YOU ADOPTED? ☐ YES ☐ NO AGE? _____

WOULD YOU RATE YOUR CHILDHOOD LIFE AS: ☐ VERY HAPPY ☐ HAPPY ☐ AVERAGE ☐ UNHAPPY ☐ VERY UNHAPPY

AS A CHILD, DID YOU FEEL CLOSER TO: ☐ YOUR FATHER ☐ YOUR MOTHER ☐ ANOTHER _____

LIST YOUR CHILDREN IN BIRTH ORDER AND NAME OF THEIR PARENT

	NAME	AGE	SEX	LIVING	MARRIED	PARENT
1.						
2.						
3.						
4.						

ARE THERE ANY SPIRITUAL CONCERNS OF WHICH YOU WOULD LIKE YOUR THERAPIST TO BE AWARE? _____

_____

For Office Use Only:

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_____

SECTION V. MEDICAL INFORMATION

RATE YOUR PHYSICAL HEALTH: □ GOOD □ AVERAGE □ POOR

LIST IMPORTANT PRESENT OR PAST ILLNESSES OR INJURIES: (*Include any hospitalizations and dates)*

_____

_____

DATE OF LAST MEDICAL EXAMINATION _____ PHYSICIAN'S NAME _____

YOUR REGULAR (PRIMARY CARE) PHYSICIAN, IF DIFFERENT _____

ARE YOU PRESENTLY TAKING PRESCRIPTION MEDICATION? □ YES □ NO

WHAT AND HOW MUCH?

_____

_____

_____

MEDICATION GIVEN BY: □ PSYCHIATRIST □ PERSONAL CARE PHYSICIAN □ N/A

DO YOU SMOKE? □ YES □ NO HOW MUCH? _____

DO YOU DRINK ALCOHOL? □ YES □ NO HOW MUCH? _____

DO YOU USE OTHER SUBSTANCES AND IF SO WHAT, HOW MUCH, AND HOW OFTEN? _____

_____

ANY OTHER COMPULSIVE BEHAVIOR? _____

_____

HAVE YOU EVER BEEN TREATED OR SEEN BY A PSYCHIATRIST? □ YES □ NO WHEN? _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

HAVE YOU EVER BEEN TREATED OR SEEN BY ANOTHER COUNSELOR? □ YES □ NO WHEN? _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

NAME: _____ APPROX. NUMBER OF SESSIONS _____

For Office Use Only:

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