M. J. Murphy Counseling Services, Inc.

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Personal Data Form

The information requested below is to help me understand you and your concerns. Please fill out all pages as completely as possible. Information will be held in confidence. You may want to write on the back of a page to answer some questions. If you prefer to discuss certain issues in person, write "discuss later" beside that item.

Today's Date _____ Date of Birth_____ Age_____

Name_____ _____
Last First Middle Nickname or Preferred Name

Home Phone _____ Work _____ Cell _____

Address_____
Street City State Zip
Single_____ Married____ Separated____ Divorced____ Widowed____ Significant Other/Partner ____

Family Physician_____ Date of Last Exam _____

Employer_____ Full Time___ Part Time_____
Occupation _____ E-mail address_____

Referred to Mary Jane Murphy by _____
May I thank this person for the referral? YES NO

Are You Currently Involved in Any Legal Action? YES NO
Do you expect to have any significant upcoming Legal Action? Describe. (for example, divorce or child custody issues)_____

MEDICAL HISTORY

What are any significant medical conditions you have, past or present?_____
_____

Current Medications For What Condition Prescribed By
_____
_____
_____
_____

Previous Therapists Dates For What Concerns
_____
_____
_____

Are You Seeing Another Therapist Presently? If so, provide name_____

How much alcohol do you consume weekly? none 2-4 drinks 5-10 drinks more than 10 drinks
Do you think you have a problem with alcohol or drugs? YES NO
Have other people told you that they think you have a problem in this area? YES NO
Was there a time n your life when you drank more than you do now? YES NO
Do you use any other substances, such as prescription or recreational drugs, to feel better? YES NO

Personal Data Form (2)

FAMILY HISTORY

Mother's Name_____ Age_____ Deceased_____
date

Did you live with her growing up? YES NO
Any mental illness? YES NO
Any substance abuse? YES NO
Any other abuse? YES NO

Father's Name_____ Age_____ Deceased _____
date

Did you live with him growing up? YES NO
Any mental illness? YES NO
Any substance abuse? YES NO
Any other abuse? YES NO

Brothers / Sisters

Name	Age	Sex	Deceased? Date

Any substance abuse by siblings? YES NO
Any other abuse by siblings? YES NO

List the friends you view as your core support system:_____
_____
_____

List the family members you view as part of this core support system:_____
_____
_____

Are you currently in a marriage or other long term relationship? If so, please describe _____
_____
_____

Describe any previous marriage or long term relationship_____
_____
_____

Children in Order of Birth

Name	Age	Sex	(Deceased? Date)

Any substance abuse with children? YES NO
Any medical issues, emotional problems or learning disabilities with children? YES NO
If so, please describe_____
_____
_____

Personal Data Form (3)

Briefly describe your faith history. Were you raised to practice a particular religion? Do you currently have spiritual practices that serve as a resource for you? Have you experienced any changes or loss of meaning in this area? What makes life meaningful to you?

_____
_____
_____
_____

PRESENT CONCERNS

Circle the Word That Best Describes Your PHYSICAL Condition At This Time

POOR FAIR AVERAGE GOOD EXCELLENT

Circle the Word That Best Describes Your EMOTIONAL Condition At This Time

POOR FAIR AVERAGE GOOD EXCELLENT

What do you see as your personal strengths and what has worked in the past to help you cope?_____
_____
_____
_____

What are your main reasons for seeking counseling at this time?

_____ ALCOHOL OR DRUGS
_____ ANGER
_____ ANXIETY
_____ DEPRESSION
_____ EATING PROBLEMS
_____ EMOTIONAL ABUSE
_____ FATIGUE
_____ FEAR
_____ GRIEF
_____ GUILT
_____ HOPELESSNESS
_____ LONELINESS
_____ OTHER _____

_____ LOSS OF MEANING
_____ MARITAL CONCERNS
_____ MOOD SHIFTS
_____ NERVOUSNESS
_____ PARENTING CONCERNS
_____ PANIC ATTACKS
_____ PHOBIAS
_____ PHYSICAL ABUSE
RELATIONSHIP WITH:
_____ CHILDREN
_____ SIGNIFICANT OTHER
_____ PARENTS

_____ RELIGIOUS DOUBTS
_____ SELF-DOUBT
_____ SELF-ESTEEM
_____ SLEEPING PROBLEMS
_____ SEXUAL ABUSE
_____ SEXUAL PROBLEMS
_____ STRESS
_____ SUICIDAL FEELINGS
_____ VOCATIONAL ISSUES

Has something happened recently to worsen any of these symptoms? _____
_____

Please state in your own words the concerns you bring to counseling at this time. _____
_____
_____
_____
_____

Do you have any desired goals for counseling? If so, what are they? _____
_____
_____
_____