Personal Information Sheet

(confidential)

File #_____

Name: _____Date:_____

Male Female Birth Date: _____Occupation: _____

Marital Status: ____ Never Married _____ Married (how long? _____ # of times? _____)
____ Widowed _____ Divorced (how long? _____# of times? _____)

Spouse's Name (or parent, if patient a minor):_____

How were you referred to Dr. Blakeslee? _____.

If this is a professional referral, may Dr. Blakeslee contact them to let them know you have met and begun treatment? _____. Signature:_____.

Briefly describe what brings you in to Dr. Blakeslee at this time: _____
_____
_____
_____

Symptom Checklist (please check items which you are experiencing or have recently experienced):

____ Mood Swings	____ Physical Violence	____ Memory Problems
____ Lack of Energy	____ Hopeless Feelings	____ Too Little Sleep
____ Excess Energy	____ Drinking Problems	____ Too Much Sleep
____ Racing Thoughts	____ Wish to Die	____ Angry Feelings
____ Slowed Thinking	____ Suicide Attempts	____ Panic Attacks
____ Guilt Feelings	____ Confusion	____ Unsure of Reality
____ Unusual Experiences	____ Fears	____ Unsure of Identity

____ Other: _____

Medical History (Please check any symptoms you have had in the last 6 months):

____ Headaches	____ Pregnancies	____ Impaired Vision
____ Seizures	____ Miscarriage	____ Impaired Hearing
____ Alcohol Use	____ Abortion	____ Chest Pain
____ Drug Use	____ Dizzy Spells	____ Hypertension
____ Weight Gain	____ Fainting	____ Stomach Discomfort
____ Weight Loss	____ Blackouts	____ Muscle Spasms
____ Compulsive Dieting	____ Numbness	____ Tremors
____ Vomiting	____ Back Pain	____ Sexual Difficulties

Have you ever been in counseling before? _____ If so, When? _____
Counselor Name:_____ Location: _____
Reason: _____

Have you ever been hospitalized for an emotional or psychological disorder? _____
If so, When?_____ Hospital:_____
Reason:_____

List any medications you are currently taking:_____
_____
_____

Describe any major diseases or injuries you have had: _____
_____
_____

Family History (Has anyone in your extended family experienced any of the following):

____ Depression	____ Anxiety	____ Mood Swings
____ Schizophrenia	____ Suicide or Attempts	____ Alcohol Use
____ Emotional Illness	____ Imprisonment	____ Drug Use

Are your parents alive? _____ Mother _____ Father.

Are your parents in good health? _____ Mother _____ Father.

Do you have children? _____ If so, how many and what are their names and ages?
_____.

Employment History:_____
_____
_____

Educational Background:_____
_____
_____

Legal History:_____
_____
_____

Briefly, please list your goals for therapy:_____
_____
_____
_____