Healing Edge NW
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Peoria, AZ 85382
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PERSONAL INFORMATION FORM

Name:____
Address:_______________________________________ City____________ Zip________
E-mail Address___________________________ Date of Birth_____________________
Phone (home):___________________________ (work)_________ (cell)_____________
Where may we call you? ___ Home ___Work ___ Cell
Leave message:? ___Home ___Work ___ Cell

Primary Health Insurance Plan___________________
Policy Holders Name:____
Health Plan ID#:_____________________________ Group ID #:_________________
Policy Holder's DOB:__________
Emergency contact & phone:____

Education (years completed or highest degree):________________________________

Marital Status __ Never Married __Divorced __ Widowed __Married (date) ________

Employer:____

Current Occupation:____

Spouse/Partners Name:____

Spouse/Partners Occupation:____

How did you hear about us?
____

Patient's
Signature________________________________Date:______________________

Home

Does anyone live with you? If so please list name(s) and relationship to you.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Number of previous marriages:__________________

LIST/DESCRIBE WHAT CHANGES YOU WANT TO MAKE WHILE IN COUNSELING:

____
____
____
____
____

What causes the problem(s)?

____
____

When did it start?____________________

____

FAMILY HISTORY:

			Relationship				
	Yes	No	Mother	Father	Brother	Sister	Grandparent
Drugs/Alcohol:	___	___	______	______	______	______	______
ADHD:	___	___	______	______	______	______	______
Depression	___	___	______	______	______	______	______
Mental Illness	___	___	______	______	______	______	______

Other (Diabetes Thyroid Tourette's, Seizures, Hypertension) ____________________

____
____
____

MEDICAL HISTORY

Are you currently under the care of a physician ____Yes ____No. Reason_____________

When was your last checkup?____

Please list any prescriptions or over the counter medications you are currently taking:

____

____

____

Doctor's name___________________________ Phone number:_______________________

Current medial issues:____

____

Past medical issue:____

____

____

TREATMENT HISTORY

Have you ever received counseling for any reason? (If yes, please list when and why)

____

____

Have you ever been hospitalized for a psychiatric reason? (If yes, please list when and why)____

____

Have you ever received treatment for drugs or alcohol? (If yer please list when and why)____

____

Have you ever attended any self-help groups such as AA, CODA, etc.?

____

WEIGHT __Unchanged __Weight gained (Last 6 mo)___________

__ Wt. Loss (6 mo)______________

__ Purging (Freq.)________/_______ __ Binging (Freq.)________/ ________

__ Laxative Use. __Diuretic use __ Diet Pills

__ Menstrual Problems (Explain)_____________________________________

____

____

SLEEP __Unchanged __Can't fall asleep __Sleep constantly

__Awaken early __Nightmares __I sleep but I don't feel rested

Comments:____

____

____

SUBSTANCE/ALCOHOL USE

Do you or have your ever had a substance abuse problem? __ No __Yes __Now __Past?
Have other people thought you might have a substance abuse problem __No __Yes __Currently
Do you believe someone in your family might have a substance abuse problem? __No__Yes Who_______
Method/Frequency/Date of last use/Type of drug: __IV __Snorted__Swallowed__Smoked

____

Do you use tobacco? __No__Yes If so, how much daily?_________________________________

Alcohol Use:
Frequency:________________________ Usual drinks/sitting________________Intoxication:_________

ALCOHOL RELATED EXPERIENCES IN THE LAST SIX MONTHS

__Binges __Job Problems __Sleep disturbance __Physical withdrawal
__Hangovers __Arrests __Blackouts __Medial complications
__Assaults __Passed Out __Seizures __Concern over driving
__DUI __Interpersonal problem __Inability to stop after 1st drink

Other Substance use (in the last six months)
Substance:_________ Freq.:_______________ Amount:___________ Duration:___________
Substance:_________ Freq.:_______________ Amount:___________ Duration:___________

SUICIDAL THOUGHT: __Yes, current __Yes in the past __No

SUICIDAL PLAN OR INTENT: __Yes current __Yes, In the past __No

If you feel like hurting yourself now do you have a plan? (If so please explain)

____
____
____

Past attempts: __No __Yes # of attempts____________ Self-mutilation______________________
Date of last attempt:______________________Method:_______________________________________

HOMICIDAL THOUGHTS: __Yes __Yes, In the past __No

HOMICIDAL PLAN OR INTENT: __Yes, current __Yes, In Past __No
If you feel like hurting someone now, do you have a plan? (If so, please explain)

____
____
____

Have you ever been violent or hurt someone? __No. __Yes (If so, please explain using dates)

____
____

Is there anything else you think we should know in order to be helpful?

____
____