Psychologist (License # PSY6581)
611 Alameda de las Pulgas
Belmont, CA 94002
(650) 255-0460
e-mail: drmarkhoward@comcast.net
website: www.drmarkhoward.com

ADULT PERSONAL DATA SHEET

Date: _____

NAME

ADDRESS | CITY | ZIP

HOME PHONE | WORK PHONE

AGE | SEX | BIRTHDATE | PLACE OF BIRTH

EMERGENCY CONTACT | PHONE

REFERRED TO THIS CLINIC BY: | MILITARY SERVICE

OCCUPATION | HOW LONG ON PRESENT JOB

EMPLOYER | USUAL WORK HOURS

HOW LONG HAVE YOU LIVED IN THIS AREA? | LAST SCHOOL GRADE COMPLETED

CHECK ONE: ☐ Married/Partnered ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

LIVING WITH SPOUSE/PARTNER: ☐ Yes ☐ No | NUMBER OF YEARS

ETHNICITY | RELIGION

Do you have a work-related problem? ☐ Yes ☐ No

Are you currently on:

a) Workers' Compensation? ☐ Yes ☐ No
b) SSI? ☐ Yes ☐ No
c) State Disability? ☐ Yes ☐ No

Do you want to initiate a Workers' Compensation or disability claim at your appointment? ☐ Yes ☐ No

TYPE(S) OF HELP DESIRED:

☐ Medication Therapy ☐ Counseling/Therapy ☐ Substance Use/Abuse Treatment
☐ Group Counseling ☐ Family Counseling ☐ Couples Counseling ☐ Other: _____

1. Major reason(s) for seeking help at this time: _____

2a. How long have you had these problems or symptoms? _____

2b. How often do they occur? _____

3. Why did you decide to seek help now? _____

4. What have you tried? _____

5. Past Psychiatric Treatment

			Type (Individual/Family)?	By Whom?	Year?	Helpful? (Y/N)	
Counseling or Psychotherapy	Yes	No				Yes	No
			1.				
			2.				
			3.				
			4.				
			5.				

			Name of Medication?	By Whom?	Year?	Helpful? (Y/N)	
Psychiatric Medication(s)	Yes	No				Yes	No
			1.				
			2.				
			3.				
			4.				
			5.				
			6.				
			7.				

			Where?	Why?	Year?	Helpful? (Y/N)	
Psychiatric Hospital Admissions	Yes	No				Yes	No
			1.				
			2.				
			3.				
			4.				
			5.				
			6.				

6. Check items below that apply to your current and past condition(s):

	Current	Past		Current	Past		Current	Past
Headaches								
Dizziness			Restlessness			Hear voices others don't hear		
Stomach/bowel trouble			Decreased need for sleep			See things others don't see		
Health problems			Mood swings			Strange experiences		
Pain			Excess energy &/or feeling wired			Feel people plot against you		
Tremors or tics						Constant suspicion/distrust		
Drug &/or alcohol cravings			Confusion			Unusual thoughts		
Eating problems			Elated/euphoric mood			Someone physically harming you		
Binge eating			Excessive spending			Thoughts of physically harming		
			Racing/overflow of thoughts			someone else		
						Violent/aggressive behavior		
Sleep problems			Irritable					
Weight loss			Impulsive behavior			Physical abuse		
Weight gain			Grandiose thoughts/plans			Sexual abuse		
Loss of appetite			Anger or explosiveness			Sexual problems		
Feeling apart from others						Relationship problems		
Low energy			Panic attacks					

6. continued . . .

	Current	Past		Current	Past		Current	Past
Memory problems			Fears			Financial problems		
Thoughts of suicide			Nightmares			Conflict in family		
Planning suicide			Fears of losing self control					
Feeling depressed			Recurring unwanted thoughts/ behaviors					
Crying a lot			Always worried					
Unable to have a good time			Concentration problems					

7. Do you have any serious or chronic medical conditions (including past surgeries) ☐ Yes ☐ No

If yes, date(s) and details: _____

8. Do you have any serious medical accidents or injuries, head injury, or seizure history? ☐ Yes ☐ No

If yes, date(s) and details: _____

9. Are you currently taking any medications (include over-the-counter and herbal)? ☐ Yes ☐ No

If yes, please list: _____

10. Have you had any allergic reactions to, or other problems with medications? ☐ Yes ☐ No

If yes, details: _____

11. ALCOHOL AND OTHER DRUG USE:

A. Do you use alcohol? ☐ Yes ☐ No

How much per day/week? _____ Age when you started drinking? _____

Last drink taken (time and amount): _____

B. Do you use other drugs? ☐ Yes ☐ No

What kind? _____

How much? _____

Age you started using? _____

Last drug use (time and amount): _____

C. Do you feel you have a problem with:

Alcohol ☐ Yes ☐ No

Other drugs ☐ Yes ☐ No

If so, explain: _____

D. Previous treatment programs (list dates and locations, if possible): _____

E. Has your drinking/drug use caused problems in the family or with your relationships? ☐ Yes ☐ No

F. Caused problems on your job? ☐ Yes ☐ No

G. Is it difficult for you to stop or control the amount you take? ☐ Yes ☐ No

H. Have you ever been arrested for a D.U.I. (driving under the influence) or other drug related offense(s)? ☐ Yes ☐ No ☐ Yes ☐ No

If so, when? _____

I. Have you ever used tobacco products? ☐ Yes ☐ No

What kind and how much? _____

When did you start? _____

When did you stop? _____

J. How many cups of caffeinated beverage(s) do you drink per day? (coffee, tea, colas & chocolate):

12. Have you had any financial problems, legal difficulties/problems or previous imprisonment? ☐ Yes ☐ No

If yes, dates and details:

13. Have relatives/significant others had psychiatric symptoms or drug or alcohol problems? ☐ Yes ☐ No

Relative	Symptoms/Problems	Treatment	Psychiatric Medications	Psychiatric Hospitalizations

14. Have any family members had problems with criminal offenses, been in jail/prison? ☐ Yes ☐ No

If yes, who, why?

15. FAMILY DATA

Name	City Residence	Check (✓) if living with you	If living, age	If deceased age at, and year of death	Occupation	How do/did you get along
Spouse / Partner						
Children						
Father						
Stepfather						
Mother						
Stepmother						
Siblings/Step Siblings						
Others in household						