

PERSONAL INFORMATION FORM (Mark Morris, LCSW)

Name _____ Date _____
 First Middle Last

Address _____
 Street City ST Zip

Phone Numbers _____

EMAIL _____

AGE _____ DATE OF BIRTH _____ OCCUPATION _____

EMPLOYER/SCHOOL _____

EMERGENCY CONTACT _____
 Name Relationship Phone

MARITAL STATUS _____ NAME, AGES, AND RELATIONSHIPS OF THOSE WHO LIVE WITH YOU (PARTNER, CHILDREN, PARENTS, PETS, ETC.)

NAMES AND AGES OF PARENTS AND SIBLINGS IN BIRTH ORDER (INCLUDING YOU): _____

_____ CURRENT THOUGHTS OF SUICIDE OR SELF-HARM? (PLS DETAIL IN SELF-ASSESSMENT)
YES / NO

_____ CURRENT DRUG OR ALCOHOL EXCESS (PLS DETAIL IN SELF ASSESSMENT)
YES / NO

REFERRAL SOURCE(S). IF YOU SEARCHED ONLINE, WHAT SEARCH WORDS DID YOU USE? SITES DID YOU VISIT? _____

DID YOU VISIT WWW.MARKMORRISLCSW.COM BEFORE SPEAKING WITH MARK? _____

HAVE YOU VISITED WWW.LIVINGYES.ORG? _____

WHY DID YOU SELECT MARK? _____

(back page)

SELF-ASSESSMENT (Mark Morris, LCSW)

(This column is for Mark's use.)

Answering this self-assessment will save time at our first session, so please answer all the questions as fully as you can. Of course, if you would rather talk than write about these issues and recognize that may take multiple sessions, feel free to skip any or all of this self-assessment. Please type, print, or write neatly. If you need more writing space, please write on the back or on a blank sheet.

Please review the office policies, including confidentiality limits and the 36-hour cancellation fee.

Current stressors / chief complaint / recent symptoms

What brings you in to therapy at this time? When did each problem start?

Physical Health

How is your physical health? Any internal diseases, surgeries, disabilities, long hospitalizations? If you have pain, where is it and how bad is it on a scale of 1 to 10 at the moment? How bad can it get on a scale of 1 to 10?

Medications

What non-psychiatric medications do you take and for what? Please include any significant over the counter use.

Primary Care Physician

Who is your primary care doctor? Where do they work? When was your last physical? Next physical?

Psychiatrist

Who is your prescribing mental health doctor? Where do they work? When was your last mental health visit? Next visit?

Psychiatric Diagnosis

What mental health diagnoses have you received? Do you think you have any undiagnosed psychiatric syndromes?

Psych Medications

What psychiatric medications do you take? What have you taken in the past?

Psychotherapy History

Please give names, dates, and duration of past psychotherapy experiences. Feel free to estimate or put your age instead of the years. What approaches did you find helpful and not helpful?

Suicidal Thoughts

Do you ever think about hurting yourself? Have you thought about it recently or currently? (Note: if you are actively suicidal, confidentiality limits are superseded.)

Suicidal History

Have you ever planned to hurt yourself? Have you ever attempted to hurt yourself? If so, please describe each incident and what happened.

Homicidal Thoughts or Attempts

Have you ever attempted to hurt (that is, kill) someone else? Are you considering hurting someone else? (Note: if you threaten to kill someone, confidentiality limits are superseded.)

Prior Mental Health Hospitalization

Have you ever been hospitalized for mental health? If so, please provide dates, duration, and an explanation for each event.

Prior Addiction Treatment

Have you ever been in addiction rehab – in-patient or out-patient – for drugs, alcohol, or behavior? If so, please provide dates, facility, type, duration, and an explanation for each event.

Drug/alcohol use (present and past); Addiction; Risky Behaviors.

What specific drugs have you used? How many times for each? At what ages for each? When last used for each? Have you ever abused or been dependent on alcohol in the past? Do you have any at-risk behaviors? Do you have any other addictive behaviors such as gambling, lust, or food?

Current Alcohol Use

Audit C questionnaire. Please **circle** the answer to these three questions and write the total.

1. How often did you have a drink containing alcohol during the past year?
Never (0 points), Monthly or less (1 point), 2-4 times a month (2 points), 2-3 times a week (3 points), 4 or more times a week (4 points).
2. How many standard drinks containing alcohol did you have in a typical day during the past year?
1 or 2 (0 points), 3 or 4 (1 point), 5 or 6 (2 points), 7 to 9 (3 points), 10 or more (4 points)
3. How often have you had six or more drinks on one occasion during the past year?
Never (0 points), Less than monthly (1 points), Monthly (2 points), Weekly (3 points), Daily or almost daily (4 points)

Total point score: _____

If your score is 3 or higher (for woman) or 4 or higher (for men) please download and review the Audit C Overview on the "for new clients" page. After reviewing, how much do you intend to drink/use going forward?

Please comment:

Psychosis:

Do you ever hear voices outside your head? See things that are not there?
Experience paranoia or what others might view as delusions?

Legal

Have you ever been arrested? Please provide year, charges, jail time served,
disposition and an explanation of each event.

Homeless

Have you ever been homeless more than 10 days? If so, please explain.

Current Family Members (objective)

Do you have a spouse/partner? How long have you been married/together? Any
previous marriages? Any other significant relationships? Do you have children?
What are their names and ages? Who lives with you, including pets? Do you
have any grandchildren? What are their names and ages?

Current Family Members (subjective)

How well do you get along with your current family members? Are there any
specific problems with current family members?

Family of Origin History (objective)

Where were you raised? Did both parents raise you? Please provide names, ages, and relationships of your family of origin (parents, siblings, others who lived with or nearby you). Where are you in the birth order? Are any of these people deceased? Was there anyone else significant in raising you? Where are your family members now?

Family History (subjective)

How well did you get along with each of these family members then and now? How would you describe your childhood? Was there mental abuse growing up? Were you physically abused?

Family Mental Health and Addictions History

Is there anyone in your bloodline with any type of mental illness (either diagnosed or not) or substance abuse? Please describe to the best of your ability and indicate the family relationship.

Educational Background

How far did you go in school? Please include completion date, degree, school, field of study. Where did you go to high school and what year did you graduate?

Military

Have you ever served in the armed forces? Which branch? What years? Where? Current or final pay grade. What was your job (MOS)? Did you see combat? Did you enjoy being in the service?

Trauma

Please describe past trauma including motor vehicle accidents. You may make reference back to childhood mental or physical abuse. What may have or still causes you nightmares?

Employment history

Please summarize your work experience including years, duties, and employers.

Employment/Daytime activities

What do you do during the day? How much time do you spend watching screens (television, videogames, internet) per day?

Leisure/recreation

What do you do for fun? What did you used to do for fun that you don't do any more?

Spirituality

Do you believe in a higher power? If so, what do you call it? Do you go to church? If so, where and how often? In what religion were you raised? What is your relationship with that religion now? Do you pray? Do you meditate?

Support System

When you're feeling down, who do you call first? Even if this is challenging, please put down a name. If that person weren't around, who would you call next? Please put down three to five names and their relationship to you. If not, why isn't your spouse or parent on your list?

Coping Skills

When you feel sad or anxious, what are the coping skills you know and use to manage your feelings?

Sleep

How well do you sleep? Please provide specific hours for the past week or two. What is the quality of your sleep?

Diet

How well do you eat? Please describe your diet in specific detail. Too much/too little? Quality or junky food? Processed or organic? Raw? How much caffeine drinks such as sodas, coffee, tea, boost drinks?

Exercise

Please describe your physical activity. How many minutes per day and times per week do you intentionally get your heartbeat elevated? How many pounds are you from your ideal weight?

Additional

Are there any other points that you would like to share that have not been asked?

If you are possibly interested in EMDR, please complete the additional material.

Goals for treatment

What do you hope to get out of therapy?

Smart Goals

Please attempt to identify 5-7 "SMART" Goals (**Specific, Measurable, Attainable, Realistic, Time Framed**) for a 6-8 week time frame. Subjective measures are okay.

1.

2.

3.

4.

5.

6.

7.