Susan K. McCrea, Psy.D.

Personal Data Form

All information is confidential

Name: _____

Cell Phone: _____ Other Phone: _____

Address: _____

Email: _____

Occupation: _____ Education: _____

Date of Birth: _____ Age: _____

To notify in emergency: Name: _____ Telephone: _____

Relationship: _____

MAIN CONCERNS

What are your reasons for coming here? _____

_____

_____

How long has this bothered you? _____

Have you had previous counseling, psychotherapy, psychiatric treatment, or psychological testing?

Yes ___ No___ If yes, please list clinicians and dates:_____

_____

_____

HEALTH HISTORY

List all important present or past illnesses, injuries, or handicaps: _____

_____

_____

Family Doctor:_____ Date of last medical exam: _____

Phone: _____

Address: _____

Please list any medications you are taking, including prescriptions, over-the-counter, and vitamins:

Name of Medication	Dose/frequency	Reason for Taking	Date started

Is there a history of mental health diagnosis in your family? Yes ___ No___

If yes, please describe: _____

MARRIAGE AND FAMILY INFORMATION

Marital Status (please circle):

Single Married Separated Divorce Widowed Partnered Other:_____

Name of spouse: _____ Years married: _____ Length of Relationship: _____

Previous marriages (date): _____

Children: _____

How did you hear about me?_____

_____

How are you hoping therapy will help?_____

_____

_____

_____

_____

_____

_____

_____