R. Ray Clark, Ph.D.

One Northgate Square
2 Garden Center Drive, Suite 205 - Greensburg, PA 15601

Personal Information Form

1. Name: _____ Preferred Name:_____ 2. Date of Birth: _____

3. Age: _____ 4. Preferred Gender: _____ 5. Ethnicity: _____

6. Relationship Status: *Single Married Partnered Separated Divorced Remarried Widowed Other*

7. Number of dependent children: _____

8. Living arrangement: *Alone Roommate(s) Spouse/Partner Children Parent(s) or other Family Other*

9. Full Address (including zip code):

_____

_____

10. Is it okay if I send any necessary mail to your address? *Yes No* 10a. Is it okay if I e-mail you? *Yes No*

10c. E-mail address: _____

11. Home phone: _____ Work Phone: _____ Cell Phone: _____

12. Is it okay if I leave a message? *Yes No* If yes, on which number? _____

13. Occupation: _____ 14. Place of Employment: _____

15. Highest Education Attained: *Grade School High School Associates Bachelor's Master's Doctorate*

16. Name and Phone Number of Person to Contact in Case of Emergency: _____

17. Medical issues can affect one's emotional state. If you have any medical problems or physical symptoms, please list:

_____

_____

18. Current Medication(s) and Name of Physician(s):

_____

_____

19. Past Medication(s):

_____

_____

20. Previous Psychological or Psychiatric Treatment (Dates, Place, & Name of Clinician):

_____

_____

_____

21. Please write a short description of the concern bringing you to therapy now:

_____

_____

_____

22. Who referred you? *Self Friend University Employer Physician Spouse/Partner Parents Other*_____

23. Please respond to the following statements.

a. Have you been having suicidal thoughts?	NO YES
b. Have you been thinking of hurting someone?	NO YES
c. Do you drink alcohol frequently or to excess?	NO YES
d. Do you drink use “recreational” drugs frequently?	NO YES
e. Have you been having panic attacks?	NO YES
f. Are you often uneasy or anxious around other people or in public?	NO YES
g. Have been worrying excessively or anxious about things in your day-to-day life?	NO YES
h. Have you been feeling sad or depressed?	NO YES
i. Have you been feeling irritable?	NO YES
j. Have you ever been unusually full of energy for several days at a time?	NO YES
k. Have you ever needed a lot less sleep than you typically need?	NO YES
l. Have you had trouble sleeping?	NO YES
m. Have you had any changes (up or down) in your eating habits?	NO YES
n. Have you ever experienced or witnessed an extremely traumatic event?	NO YES
o. Have you had recurrent thoughts or images that you couldn’t get out of your mind?	NO YES
p. Are there any particular behaviors you feel you have to do repeatedly and cannot resist?	NO YES
q. Have you had unexplained time loss or found yourself places and not known how you got there?	NO YES
r. Have your relatives or friends ever considered any of your beliefs to be strange or out of reality?	NO YES
s. Have you ever heard or seen things that others could not?	NO YES
t. Have you ever been diagnosed with an eating disorder or thought you might have one?	NO YES
u. Do you often have headaches, stomachaches, or other physical discomfort?	NO YES
v. Have you been having symptoms other than those above? NO YES If yes, list them here:	