**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: \_\_\_\_\_ 4a. Preferred Gender: \_\_\_\_\_\_\_\_\_\_ 4b. Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_ 5. Ethnicity (Optional): \_\_\_\_\_\_\_\_\_

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

7a. Number of dependent children: \_\_\_\_\_\_\_ 7b. Number of adult children: \_\_\_\_\_\_\_

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

9. Full Address (including zip code):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

10c. E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Okay to leave a message? *Yes No* If yes, on which number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 14. Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15. Highest Level of Education: *Grade School High School Associates Bachelor’s Master’s Doctorate*

16. Emergency Contact Person (Name & Number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. Medical issues can affect one’s emotional/mental 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 (Approximate Dates, Place, & Name of Clinician):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. Please write a brief description of the concern(s) bringing you to therapy *now*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

23. Please answer if you are currently (or recently) experiencing any of the below:

|  |  |
| --- | --- |
| 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: | |