

Denise Humphrey, Ph.D.
Clinical Psychologist
6320 LBJ Freeway, Suite 221
Dallas, TEXAS 75240
972-239-2490
www.denisehumphrey.com
PERSONAL DATA SHEET AND QUESTIONNAIRE

Instructions

In order to provide the best care possible, please fill out the following pages as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply, leave them blank. Please initial the bottom of each page and sign the last page of the questionnaire.

Today's Date _____ Date of Birth _____

Full Legal Name _____

Address _____
Street City State Zip

May we send mail to this address? _____ Yes _____ No

Phone Numbers _____
Home Work Mobile

May we leave detailed messages at these phone numbers?

Home: _____ Yes _____ No
Work: _____ Yes _____ No
Mobile: _____ Yes _____ No

Please note: If you do not authorize leaving a detailed message, messages will be left as follows: "This is Denise Humphrey. Please call me back at 972-239-2490." Messages will not refer to or specify that this is a psychologist's office, although my name might appear on caller ID.

Emergency Contact _____
Name Phone Relation to You

Personal Description

What is your highest education level? _____

What is your race/ethnicity? _____

What is your sexual orientation? _____

Place of employment? _____ Length of time at this job _____

Client initials _____

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Children Yes No

If yes, name and ages _____

What is your current relationship status (married, single, divorced, committed relationship)?
Circle one.

What are the main reasons you are seeking psychotherapy at this time?

What stressful events have recently occurred?

Check the symptoms and problems areas that you are currently experiencing:

<input type="checkbox"/> Acting Out	<input type="checkbox"/> Discrimination	<input type="checkbox"/> Procrastination
<input type="checkbox"/> Aggression	<input type="checkbox"/> Disorientation	<input type="checkbox"/> Recurring/Unwanted Thoughts
<input type="checkbox"/> Agitation	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Relationship Problems
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Religious/Spiritual Concerns
<input type="checkbox"/> Anger	<input type="checkbox"/> Elevated Mood	<input type="checkbox"/> Self-Esteem/Self-Confidence
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fatigue/Loss of Energy	<input type="checkbox"/> Self-Harm (e.g. cutting)
<input type="checkbox"/> Appetite Change	<input type="checkbox"/> Feelings of Worthlessness	<input type="checkbox"/> Sexual Assault/Unwanted Sex
<input type="checkbox"/> Avoiding People	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Sexual Concerns
<input type="checkbox"/> Bingeing/Purging	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Sexual Orientation/ID Issues
<input type="checkbox"/> Body Image	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Sick Often
<input type="checkbox"/> Break-up of a Relationship	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Internet Use/Abuse	<input type="checkbox"/> Suicidal Thoughts/Feelings
<input type="checkbox"/> Concentration Impairment	<input type="checkbox"/> Irritability	<input type="checkbox"/> Thoughts Disorganized
<input type="checkbox"/> Confusion about Beliefs/Values		<input type="checkbox"/> Time Management
<input type="checkbox"/> Death of Significant Person	<input type="checkbox"/> Memory	<input type="checkbox"/> Trembling
<input type="checkbox"/> Decisions about Career	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Weight Loss or Gain
<input type="checkbox"/> Depression/Sadness	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Withdrawing
<input type="checkbox"/> Diminished Pleasure	<input type="checkbox"/> Phobias/Fears	<input type="checkbox"/> Worrying

When did these symptoms begin? _____

Is there anything that has helped make the symptoms/problems better? _____

Is there anything that has helped make the symptoms/problems worse? _____

How would you like to be different as a result of therapy? _____

Client initials _____

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What do you like about yourself? What are your strengths?

What do you dislike about yourself? What are your weaknesses?

What are your special interests and hobbies?

Health

Please list any significant health concerns, illnesses, injuries, or surgeries you have experienced.

What medications are you taking and for what purpose?

On average, how much sleep do you get daily? Describe any current or past sleep problems.

Please describe any current or past problems with weight and/or eating:

Please indicate which of the following substances you currently use or have used in the past:

<u>Past</u>	<u>Current</u>	Others: Please List
___	___ Alcohol	_____
___	___ Amphetamines	_____
___	___ Barbiturates	_____
___	___ Cocaine or Crack	
___	___ Heroin	
___	___ LSD/Hallucinogen	
___	___ Marijuana	
___	___ Nicotine	
___	___ Opiates	

Client initials _____

