# HUTCHINSON & ASSOCIATES — Client Personal Data Survey

222 West Gregory, Suite 100 ▪ Kansas City, Missouri 64114 ▪ (816) 361-0664

**NAME** _____ **DATE** _____

**OCCUPATION** _____ **EDUCATION** _____

If client is a minor, what school does (s)he attend? _____

What grade is (s)he in? _____

**CURRENT LIVING SITUATION** _____

**MARITAL/PARTNER STATUS** _____

**PARTNER'S NAME** *(if applicable)* _____ **AGE** _____

Employer _____ Occupation _____

| CHILDREN | AGE | SEX | SIBLINGS | AGE | SEX |
|---|---|---|---|---|---|
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| | | | | | |

What prompted you to call at this time? _____

**PREVIOUS THERAPIST(S)** *Please list therapist and approximate date.*

**PLEASE COMPLETE THE OTHER SIDE OF THIS FORM**

*Please read the following list. If you have a history of any of these symptoms, mark them "HX". Mark the ones you are presently experiencing with a "PR".*

_____ HIGH BLOOD PRESSURE
_____ LOW BLOOD PRESSURE
_____ HYPOTHYROIDISM
_____ DIZZINESS OR FAINTING
_____ MIGRAINE HEADACHE
_____ TENSION HEADACHE
_____ HEAVY DRINKING
_____ DRUG ABUSE
_____ UNSTABLE JOB PATTERN
_____ SUICIDE THOUGHTS
_____ FEARFULNESS
_____ MOODINESS
_____ UNPLEASANT IDEAS STAY IN HEAD
_____ SUICIDE ATTEMPT

_____ JOB UNHAPPINESS
_____ HEAD INJURY
_____ DIABETES OR HYPOGLYCEMIA
_____ COLITIS
_____ ULCERS
_____ POUNDING HEART
_____ MUSCLE TENSION
_____ WEIGHT PROBLEMS
_____ HEART TROUBLE
_____ COLD HANDS/FEET
_____ PANIC EASILY
_____ ANXIETY
_____ FATIGUE
_____ CHEST PAIN

_____ DECREASED OR INCREASED APPETITE
_____ INDIGESTION
_____ MEMORY PROBLEMS
_____ NUMBNESS
_____ NIGHTMARES/TROUBLE SLEEPING
_____ DEPRESSION
_____ GUILT
_____ LOW ENERGY
_____ FEELINGS OF INADEQUACY
_____ BLACKOUTS
_____ PHOBIA(S)
_____ OTHER _____
_____

## MEDICAL INFORMATION

Are you currently being treated for any medical conditions? [ ] YES [ ] NO

If yes, what conditions? _____

_____

_____

If you are taking *any* medications, or if you have taken medications recently, including "over the counter" pills for insomnia, etc., identify those medications.

Rx _____ Rx _____ Rx _____

Rx _____ Rx _____ Rx _____

**PHYSICIAN NAME(S)**

Dr. _____ Phone ( ) _____

Dr. _____ Phone ( ) _____

Dr. _____ Phone ( ) _____

**HOSPITALIZATIONS**

Please list reasons and approximate dates of any hospitalizations.

_____

_____

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