George Rinker, MS, MDiv.

Licensed Clinical Mental Health Counselor

5H2 Doctors Park

417 Biltmore Avenue

Asheville, NC 28801

404-414-1465

Personal Data Form:

In order for me to understand your situation and provide effective care, I ask you to fill out this form honestly and completely. This information is confidential and will not be released without your written permission. Thank You!

Name:_____Age:_____DOB:_____

Address:_____ City_____
State_____ Zip_____

Home Phone:_____Cell Phone:_____

Work Phone:_____Email Address: _____

Employer:_____Occupation:_____How Long?_____ Current Annual Salary: _____

Do you own or rent your home?_____

Please describe briefly the problem or situation which led you to seek counseling services at this time:_____
_____
_____
_____

How long has this been a problem? _____

Have you had this type of problem before? No_____ Yes_____ If so, when?_____

Have there been any recent changes in your life that may have caused stress (moves, deaths, changes in job or relationships, changes in physical health etc…) If so please describe:

_____
_____

Are you taking any medications? No____ Yes____ If so, list them:

_____
_____

Have you ever had any medications prescribed for psychiatric or emotional difficulties? No____ Yes_____ If so, please list and dates:

_____

_____

List any medical issues or conditions:_____

_____

How much alcohol do you drink each week? (beer, liquor or wine)

_____

Ever been treated for alcohol or drug abuse? No____ Yes_____ If so, date, length and type of treatment:

_____

Have you ever used street drugs? No___ Yes___ If so, list type, length of use and current status of use: _____

Have you ever received psychotherapy or counseling services before? No____ Yes____ If so, when, how long and for what?_____

Do you have any biological relatives who had problems similar to yours, or had psychiatric or emotional difficulties? No_____ Yes_____ If so, list who, relationship and what kind of problem:_____

What are you hoping to gain from coming to counseling and what type of treatment do you think you need?_____

Have you had any of the following: (Check)

Thoughts of harming self ____Attempts to harm self_____Thoughts to harm others _____

Describe:_____

Please list below all persons living in your present household:

NAME	Occupation	Relation to you	Age	Marital Status
1._____	_____	_____	____	_____
2._____	_____	_____	____	_____
3._____	_____	_____	____	_____
4._____	_____	_____	____	_____
5._____	_____	_____	____	_____

Signed:_____ Date_____