PERSONAL BIOGRAPHICAL INFORMATION
INTAKE FORM

Daniela Roher, Ph.D. LPC
7301 E. Sundance Trail, Suite B203
Carefree, AZ 85377
Tel. 480 595-6500

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy Form. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: ____________________ MALE/FEMALE: ____ DATE: ____________

DATE OF BIRTH/PLACE: ______________________________ AGE: _________

ADDRESS:

____

____

TELEPHONE: H: _________ Cell: __________ W/Off: _________

FOR ROUTINE MESSAGES: Phone #____________ E-mail: __________________

FOR CONFIDENTIAL/PRIVATE MESSAGES:

Phone #___________________ E-mail: _____________________

HIGHEST GRADE/DEGREE: ____________

TYPE OF DEGREE: ____________________

PERSON & PHONE NO. TO CALL IN EMERGENCY:

____

REFERRAL SOURCE:

____

____

OCCUPATION (former. if retired):

____

____

Please describe why you are seeking help at this time (be as specific as you can: when did it start, how does it affect you…):

____

____

____

____

____

FAMILY INFORMATION

CURRENT: Marital status: __ Live with someone:_ _ Name: _________
Years: __________

PAST & PRESENT MARRIAGE/S (years together, statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile.) If divorced, reasons for divorce:

____

____

____

____

____

PRESENT SPOUSE/PARTNER: ____________________________________

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1.____
2.____
3.____
4.____
5.____

Please list the names and relationships of the five most important people in your life:____

____
____
____
____
____
____
____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:____
____
____

Mother:____

____

____

Step-
parents____

____

____

____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1.____

____

2.____

____

3.____

____

4.____

____

5.____

____

PHYSICAL HEALTH

HOW DO YPOU RATE YOUR OVERALL PHYSICAL HEALTH?

Excellent___________ Great ____________ Good ____________ Fair___________
Poor____________

DO YOU HAVE ANY SLEEP PROBLEMS? Yes __________ No ___________

If Yes, Please describe:

____

____

____

____

If you have/had medical problems, surgeries, accidents, falls, illness, please describe:

____

____

____

____

____

____

____

MEDICAL DOCTOR/S (name /phone):

____

PAST/PRESENT MEDICAL CARE (major SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> clearly:

____

____

____

____

EMOTIONAL HEALTH

HAVE YOU HAD ANY PROBLEM WITH ISSUES OF DEPRESSION, ANXIETY, ADD/ADHD OR ANY OTHER MENTAL OR EMOTIONAL DISORDER? If so, please describe:

____

____

____
____
____
____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

____
____
____
____
____

HAVE YOU EVER SEEN A THERAPIST FOR EMOTIONAL PROBLEMS?____________________

Please describe times, durations, outcomes:

____
____
____
____
____
____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS?___________________

If yes, please give information (dates, reasons, outcomes)

____
____
____
____

ARE YOU CURRENTLY EXPERIENCING SUICIDAL THOUGHTS?__________________________

HAVE YOU EVER TRIED TO COMMIT SUICIDE?

If yes, please give details

FAMILY MENTAL HISTORY

HAS ANY FAMILY MEMBER BEEN HOSPITALIZED FOR MENTAL HEALTH CONCERNS? Please give details

____

____

____

DOES YOUR FAMILY HAVE A HISTORY OF SUBSTANCE ABUSE? Please explain

____

____

____

____

HAS ANYBODY IN YOUR FAMILY ATTEMPTED OR COMMITTED SUICIDE? Please explain

____

____

LEGAL HISTORY

ARE YOU CURRENTLY OR HAVE YOU IN THE PAST BEEN INVOLVED IN ANY CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (If you answer Yes, please explain):

____

____

____

____

SOCIAL NETWORK

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

____

____

____

____

____

____

DO YOU HAVE PETS? Yes ____ No _____

DO YOU EXERCISE REGULARLY? Yes _______ No _______

WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE?

____

____

____

____

WHAT ARE YOUR MAIN WORRIES AND FEARS?

____

____

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS?

WHAT DO YOU DO FOR FUN?

WHEN YOU TREAT YOURSELF, WHAT ARE SOME OF THE THINGS YOU LIKE TO DO?

PLEASE ADD ANY OTHER INFORMATION YOU WOULD LIKE ME TO KNOW ABOUT YOU AND YOUR SITUATION.

____

____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE:

Chronic sadness___ Crying episodes___ Hopelessness ___ Loss of appetite___ Difficulty concentrating--- Overeating___ Difficulty making decisions___ Low energy/fatigue___ Agitation___ Restlessness___ Irritability___ Excessive worry___ Fearfulness___ Trembling/shaking___ Excessive fears___ Intrusive thoughts___ Flashbacks___ Hearing voices___ Seeing things others don't see___ Ideas that others are talking about you/want to cause you harm___ Difficulty completing tasks___ Disorganized___ Difficulty focusing___ tendency to act impulsively___ Problems with relationships___ Overwhelmed___ Racing thoughts___ Insomnia___ Hypersomnia___ Problems with memory___ Isolation___ Lack of enjoyment/pleasure___ Lack of interest in sex___ Difficulty functioning in relationships and at work___ Palpitations___ Shortness of breath___ Panic___ Nightmares___ Relational conflicts___ Domestic violence___

Thank you.