COUPLE BIOGRAPHICAL INFORMATION
INTAKE FORM

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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 that I provide and you signed. 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: Street:_____
City:_____
State_____Zip_____

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:_____

_____

Presenting problem:

_____

_____

_____

_____

How long has this been going on? _____

BACKGROUND HISTORY

People currently living in your household:

Name	Relationship	Age	Birthplace	Occupation or grade level

_____

_____

_____

_____

_____

_____

_____

Members of your Family of Origin:

Name	Relationship	Age	Where living	Occupation or grade level

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

What is your earliest childhood memory?

_____

_____

_____

_____

_____

_____

_____

PHYSICAL HEALTH/MENTAL HEALTH INFORMATION

Have you ever seen a counselor, psychologist, psychiatrist or other mental health professional for any mental health or drug/alcohol related problems? _____

If yes, please list who, when, why and with which outcome:

_____

_____

_____

_____

Have you ever taken any medication for mental health concerns?

_____

If so, what are/were them; what dosages, and for how long?

_____

_____

_____

_____

_____

_____

With what results?

_____

_____

Has any member of your family been hospitalized for mental health concerns?_____

If yes, please list when and for what reason:

_____

_____

_____

_____

_____

_____

Do/did you have any family members who have/had problems with alcohol or drug abuse?

_____

If yes, please list who, when and if it is still a problem

_____

_____

_____

_____

_____

Has any member of your family committed suicide or attempted suicide_____

_____

_____

Please list all the current medications either of you is taking, with doses, times and reasons for taking them. Please include over the counter, herbs, vitamins and other remedies:

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_____

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_____

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_____

_____

How is your general health now?

_____

_____

_____

Please list any general health concerns you may have:

_____

_____

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU MIGHT 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___