

INDIVIDUAL 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. 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/Ofc: _____

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 YOU 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 MEDICATION you are presently taking and for what. PRINT 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.