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. All 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."

NAME: _____M/F:_____DATE:_____

SEXUAL ORIENTATION:_____ETHNICITY:_____

DATE OF BIRTH: _____PLACE: _____AGE: _____

ADDRESS:_____CITY:_____ ZIP:_____

SOCIAL SECURITY #:_____ E-MAIL: _____

TELEPHONE: H: _____W: _____CELL:_____

INSURANCE POLICY: _____ ID#_____

OCCUPATION:_____**EMPLOYER:_____**

EMPLOYER ADDRESS:_____

EMERGENCY CONTACT: _____PHONE:_____

MEDICAL DOCTOR/S (name /phone): _____

HOW DID YOU HEAR ABOUT ME?

_____

May I inform this person that you have consulted with me?_____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PRESENTING PROBLEM (be as specific as you can: When did it start, how does it affect you…):

_____

_____

_____

_____

CURRENT MARITAL STATUS: _____ Live with someone: ____ Name: _____ #Yrs:_____

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

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

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

1._____
2._____
3._____
4._____

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:_____
_____

LIST ADJECTIVES OR NOUNS TO DESCRIBE YOUR FATHER:

POSITIVE	**NEGATIVE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Mother:_____
_____

LIST ADJECTIVES OR NOUNS TO DESCRIBE YOUR MOTHER:

POSITIVE	**NEGATIVE**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Step-parents:_____
_____

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time:
_____
_____

IF YOU WERE ADOPTED, AT WHAT AGE WERE YOU ADOPTED?_____

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

1._____

2._____

3._____

4._____

5._____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

FAMILY MEDICAL AND PSYCHIATRIC HISTORY (Describe any physical or mental illness that runs in the family including depression or suicide)**:**

_____

_____

FAMILY HISTORY OF ALCOHOL/DRUG PROBLEMS (Describe any abuse of substances that runs in the family)**:**

_____

_____

FAMILY HISTORY OF VIOLENCE OR EMOTIONAL/PHYSICAL ABUSE (Towards you or other members of your family):

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. _____

_____

2. _____

_____

3. *USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS*

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

_____

_____

Prescription Drugs:

Type	Amount:	Frequency	Date last used

_____

_____

_____

_____

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

_____

_____

Coffee (#_____cups/daily)
Cigarettes (#_____ per day)
Alcohol (#_____ drinks/daily_____ or weekly_____) Date last drank:_____
Street drugs
(Type):_____Frequency:_____
Non-Prescribed Pills
(Type):_____Frequency:_____

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc)

_____

_____

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

_____

_____

SEXUAL CONCERNS: (Describe any concerns/problems/questions you have related to sex, for example: pain, performance issues, lack of desire/pleasure, compulsiveness/addiction, sexual trauma, relationship issues, etc.)

_____

_____

_____

_____

Please indicate how the following symptoms/problems/complaints are affecting you:
1)Little effect 2)Some effect 3)Much effect 4)Significant effect

(Leave blank if no effect)

___Eating habits/Appetite: eating more, eating less
___weight change; amount ___
___binge; purge
___Sleep: Trouble falling asleep; Trouble staying asleep; Trouble waking up; Average # hours sleep_____ #Naps_____
___Decreased energy/Fatigue
___Sexual functioning
___Loss of interest in activities
___Tearfulness
___Hopelessness/Helplessness
___Decreased attention span
___Inattentive/Distractible
___Memory: Long term;short term
___Difficulty planning ahead
___ Spending sprees
___ Rapid Heartbeat
___ Phobia
___ Sweating
___ Trouble Breathing
___ Flashbacks of traumatic event
___ Nightmares
___ Racing thoughts
___Impulse control; difficulty controlling physical behavior/hyperactive
___Mood changes
___Anxious/Nervous
___Worry/Fear
___ Hearing Voices
___ Seeing things that are not there
___Stealing
___Anger outbursts
___Panic attacks - Frequency_____

Rate how the problems/symptoms/complaints are impacting areas of functioning:

(Leave blank if no effect) 1)Mild 2)Moderate 3)Severe

___ Marriage/Relationship
___ Work/School
___ Family
___ Friendships
___ Financial situation
___ Physical health
___ Social interests
___ Leisure activities
___ Clubs/Group memberships
___ Legal
___ Housing
___ Attending to daily living activities (i.e. shower, grooming, self care, etc.)
___ Spirituality
___ Other:_____

What gives you most joy or pleasure in your life:

_____

_____

What are your main worries and fears:

_____

_____

What do you identify as your strengths:

_____

_____

What do you identify as your weaknesses:

_____

_____

What are your goals for treatment:

_____

_____

Please add anything in the space provided any other information you would like me to know about you and your situation.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name:_____ Date:_____

Patient Signature:_____