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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 and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring the completed form with you to the first session. Your completeness will make the best use of our time.

NAME: ________________________________ MALE/FEMALE: ____ DATE :________________

DATE OF BIRTH____________PLACE: ______________________________ AGE: __________

ADDRESS__________________________________CITY_____________________ZIP______________

SOCIAL SECURITY #_____________________EMAIL____

TELEPHONE: H: __________________ Cell: ___________________ W/Off:_____________________

EMERGENCY CONTACT:___________________________________ PHONE____________________

RELATIONSHIP TO YOU____

MEDICAL INSURANCE___________________________ ID#______________________________

SUBSCRIBER NAME:___________________________

REFERRAL SOURCE: ____

OK FOR ME TO CALL TO THANK THEM? ________YES ________NO

HIGHEST GRADE/DEGREE: _____HIGH SCHOOL ____COLLEGE ______GRAD SCHOOL

SCHOOL__________________________________ MAJOR_____________________________________

OCCUPATION______________________________EMPLOYER___________________________________

EMPLOYER ADDRESS____# OF YRS.__________

PRESENTING PROBLEM (be as specific as you can,: When did it start? How does it affect you?)
Severity: _______Mild __________Moderate _________Severe ___________ Very Severe

____

____

____

CURRENT MARITAL STATUS:_____Live with someone____ Name________________________# yrs.___

PRESENT SPOUSE/PARTNER NAME____
___ Married No. of Years____; ___Live Together No. of Years____; ___ Other

Present Spouse/Partner: Education__________________ Occupation____________________

Describe your current relationship____

____

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

____

____

____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)
1.____
2,____
3.____
4.____
5. ____

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

Mother:____
____
____

Stepparents____
____
____

IF PARENTS DIVORCED: Your age at the time: ______Describe how it affected you at the time:
____
____

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 run in the family):____
____

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

ANY PHYSICAL OR SEXUAL ABUSE IN YOUR HISTORY? ________YES ________ NO
If yes, please indicate age and severity____
____
____

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

____

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):
____

HAVE YOU BEEN INVOLVED IN ANY LEGAL SITUATIONS IN THE PAST? IF SO, PLEASE EXPLAIN____
____

MEDICAL DOCTOR ______________________________**Phone:**______________________
Address:____
Date of last physical________________________________ **Date last seen**____________________
Reason seen____
Are you currently being treated for any medical conditions, if so what____________________________

PAST CARE (major medical problems, surgeries, accidents, falls, illness):
____
____
____
Any allergies?_______________________ **Allergic to any medication?**_______________________

FAMILY MEDICAL HISTORY (Describe any <u>illness</u> that runs in the family: cancer, epilepsy, etc.)**:**
____
____
____

SPECIFY <u>MEDICATION</u> you are presently taking (prescription and over the counter) and for what, include dosage. <u>PRINT</u> clearly:
Prescription Drugs:
Type Amount Frequency Date last used
____
____
____

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

# of drinks per week ______n/a ______1-3 ________4-6________7-12___________ 13+
Has anyone complained about the amount you drink? ___Yes ___No Who___________________________
Age of first drink_______________ Treatment date_________ Where______________________________
Do you smoke? _______No _________Yes # per day_________________

Coffee(#_______ cups/daily)
Cigarettes (#______per day)
Alcohol (#_______ drinks/daily______or weekly________ Date of last drink_____________________
Street Drugs (Indicate past and present use)
(Type)_______________________________Frequency__________________________Date of last use_________
____

FRIENDSHIPS AND COMMUNITY INVOLVEMENT (Describe quality, frequency, activities, etc.):
____
____
Do you attend church ___Regularly ___Occasionally ___Never Religion___________________________
Do you consider yourself a spiritual person (belief in God/Higher Power)____Yes ___No

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.____
____
____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning-end), estimated no. sessions, name, degree, phone & address, initial reason for therapy, Indiv/Couple/Family, medication, brief description of the relationship and how helpful it was and how/why it ended)**. Please list all therapists you have worked with.**

1. ____
____
____
2. ____
____
____

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

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

___Eating habits/ appetite: eating more/less
___Weight changed; amount ________
___Binge;purge
___Sleep: Trouble falling asleep;
Trouble staying asleep;
Average # hours sleep______
 # Naps/week______
___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
___Anger outbursts
___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
___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 situations
___Physical health
___Social Interests
___Leisure activities
___Clubs/Group memberships
___Legal
___Housing
___Attending to daily living activities (i.e. shower, grooming, self care)
___Spirituality
___Other________________________

What gives you 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 identify as your strengths:

____
____

What do you identify as your weaknesses:

____
____

What do you hope to gain from counseling____

____

What else is it important for me to know about you and your situation.

____
____
____
____
____
____

Patient Name:_____________________________________ Date_________________

Patient Signature:__________________________________

Thank you for taking the time to share this information with me. I look forward to working with you.