Biographical Information – Intake Form

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 it with you to the first session.

NAME: ____ DATE: ___________

GENDER IDENTIFICATION: ____

DATE OF BIRTH and PLACE OF BIRTH: ____ AGE: ________

WHAT ARE YOUR PREFERRED PERSONAL PRONOUNS? (e.g., she/her/hers; he/him/his; they/them/theirs ...) Please circle above or write in other preferred pronouns below.

____

ADDRESS: ____

FOR ROUTINE MESSAGES: Phone #______________________ Email: _______________________

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____________ Email: _____________ Text: _____________

HIGHEST GRADE/DEGREE: ___________ TYPE OF DEGREE: _____________________________________

PERSON & PHONE # TO CONTACT IN EMERGENCY: ____

REFERRAL SOURCE: ____

OCCUPATION (former, if retired): ____

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

____

____

____

____

____

Estimate the severity of above problem: Mild ______ Moderate ______ Severe _____Very severe ______

CURRENT: Marital status: ____ Live with someone: ____ Name: ____________________ Years: ______

PAST & PRESENT MARRIAGE/S (names, years together, and 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. ____
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:____

____

____

____

____

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

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

MEDICAL DOCTOR (S) (name/phone): ____

____

PSYCHIATRIC MEDICATION PROVIDER (name/phone) ____________________________________

____

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

____

____

____

SPECIFY MEDICATIONS you are presently taking and for what. PRINT clearly:

____

____

____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g. cancer, diabetes,etc)

____

____

____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (your age/s, reasons, circumstances, how, etc.)

____

____

____

____

PAST PYSCHIATRIC HOSPITALIZATIONS: (Specify date, reason and hospital)

____

____

____

____

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

1. ____

____

2. ____

____

3.____

USE BACK SIDE OF FORM TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY: (Describe your support system and spiritual beliefs/values)

____

____

____

____

GRIEF/LOSSES/SIGNIFICANT LIFE CHANGES OR STRESSORS:

____

____

____

____

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

IF PARENTS DIVORCED: Your age/s at the time: ____
Describe how it affected you at the time
____
____
____
____

Did you experience any stressful or traumatic childhood experiences, including abuse, neglect, or a range of household stressors, such as witnessing domestic violence, or growing up with substance abuse, mental illness, parental discord, or crime in the home, etc.. (what kinds?)
____
____
____
____

LIST OF SYMPTOMS – Please circle any of the following that have been bothering you lately:

abused as child	agoraphobia	alcohol use	ambition
anger	anxiety	appetite	body image issues
bowel trouble	career choices	chronic pain	compulsions
concentration	confidence	depression	divorce
drug use/abuse	eating problem	education	energy (hi/low)
extreme fatigue	fears	finances	friend difficulties
guilt	headaches	health problems	hopelessness
home stress	inferiority feelings insomnia	loneliness	making decisions
marital issues	memory	negative thoughts	
nervousness	nightmares	obsessive thoughts	overweight
painful thoughts	panic attacks	physical symptoms	parenting concerns
phobias	relationships	sadness	self-esteem
separation	sexual problems	short temper	social anxiety
suicidal thoughts	self-harm	religion/spirituality	work stress

Other symptoms: ____

Please circle to indicate how much the issue(s) for which you are seeking treatment affects the following areas of your life:

Marriage / Relationship:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Family:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Job/school performance:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Friendships:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Financial situation:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Physical health:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Anxiety level / nerves:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Mood:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Eating habits:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Sleeping habits:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Sexual functioning:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Alcohol / drug use:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Ability to concentrate:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Ability to control anger:

1- No effect 2 - Little effect 3 - Some effect 4 - Much effect 5 - Significant effect N/A- Not Applicable

Substance Use

Do you currently consume alcohol? Yes No

If yes, on average how many drinks per occasion do you consume? ____________

How many days per week do you consume alcohol? ____________

Do you have a history of problematic use of alcohol? Yes No

Have family members or friends expressed concern about your drinking? Yes No

Do you currently use non-prescribed drugs or street drugs? Yes No

Kinds/amounts/frequencies____

____

Do you have a history of problematic use of prescription or non-prescription drugs? Yes No
Are you in recovery? Yes No Since when? ______________________________

Do you have a family history of alcohol or drug problems? Yes No If yes, please describe:
____

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):
Facebook: ______ YouTube: ______ Gaming: ______ Texting: ______ Browsing: ______
Work/School: ______ Other: ______

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:
____
____

Legal Issues: CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):
____
____
____
____

What are the best ways for you to learn?
____

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 are your goals for therapy?
____
____
____

Please add any other information you would like me to know about you and your situation.
____
____