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." Feel free to use the backside of the form to expand on any answers. **Please print or write clearly and bring it with you to the first session.**

NAME:_____ MALE/FEMALE:_____DATE:_____

SS#_____ Drivers License #_____

Date of Birth: _____Age_____ Birth Place_____

ADDRESS:_____

TELEPHONE: Home_____ Work_____
Cell _____Fax_____

EMAIL ADDRESS:_____
It is acceptable to use email to communicate other than therapy issues ___yes ____no

EMERGENCY CONTACT: Person's Name_____
Relationship_____ Home Phone_____
Business phone_____ Cell phone_____
Address: _____

REFERRAL SOURCE:_____

EMPLOYMENT:
Occupation (former, if retired) _____
Current Employer Name_____
Current Employer Address_____

EDUCATION: Highest Grade Completed: _____Degree/Certification:_____

PRESENTING PROBLEM (Why are you here, be as specific as you can, for example, when did it start, how does it effect you, why did you choose therapy now:)

_____

_____

_____

Symptoms: _____

_____

Estimate the severity of the above problem:
Mild_____, Moderate_____, Severe _____, Very Severe _____

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CURRENT RELATIONSHIP STATUS:
Married: Name of Spouse_____Years Married_____
Spouses Occupation_____Education_____
OR
Divorced_____Widowed_____Separated_____Single_____
Living with someone:_____ Name:_____ Years:_____

PAST & PRESENT SIGNIFICANT RELATIONSHIPS/MARRIAGES (name, years together, nature of the relationship ((i.e., friendly, distant, physically/emotionally abusive, loving, hostile)) and why each ended):
1_____
_____
2_____
_____
3_____

CHILDREN/STEP/GRAND (name/age, nature of the relationship with the person)
*If deceased please list name, age at death, and cause of death.
1._____

2._____

3._____

4_____

5._____

6._____

PARENT(S)/STEP-PARENT(S) (name/age or year of death/cause of death, occupation, personality, how did she/he treat you, nature of the relationship):

Father_____
_____
_____

Mother_____
_____
_____

Step-parents_____
_____
By whom were you primarily raised?_____

SIBLING(S): (Name, age, gender and brief statement about the relationship)
*If deceased please list name, age at death and cause of death.
1_____
2 _____
3_____
4_____
5_____

Health Insurance Yes_____ No_____
Company_____ Address _____
Policy and/or group #_____Phone ( )_____

MEDICAL DOCTOR/S
Primary Care Physician Name:_____
Address:_____
Phone and Fax:_____

Other Medical Specialist Name:_____
Address:_____
Phone and Fax:_____

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

_____
_____
_____

PRESENT MEDICATIONS:

Name	Dosage	Rx Physician	Medical Issue & **Start Date**

PAST /PRESENT DRUG/ ALCOHOL USE/ ABUSE (Are you attending any 12 Step groups, support groups, treatment centers, etc.)
*Please specify substance(s) *currently* using (i.e. nicotine, alcohol, cocaine, etc), how often, and in what quantities.

_____
_____
_____

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PRESENT /PAST SUICIDE ATTEMPT/S, VIOLENT BEHAVIOR or SELF HARMING Behavior such as self-mutiliating(Describe – age(s), reasons, circumstances, how, etc):

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

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

1

2

3

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

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

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

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

• • • • • • • • • • • • •

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?

Is there anything else you think I should know about you or your situation?

Thank you for taking the time and care in completing this form.