

Biographical Information Form

Please fill out this biographical background form as completely as possible. It will help me in our work together and in understanding why you are seeking help at this time. Information is confidential as outlined in the Disclosure Statement Form. If you desire to not answer a question, write DNCA for "do not care to answer." Please print or write clearly and bring it with you to the first session.

Name: _____ Male/Female: _____ Date: _____

Address: _____

Telephone: (h) _____ (c) _____ (w) _____

For **routine** messages: Phone # _____ Email: _____

For **confidential** messages: Phone # _____ Email: _____

Person & phone # to call in emergency: _____

Referral source (who/what brought you here?): _____

Date of birth _____ Birthplace: _____ Age: _____

Highest education: _____ Type of degree: _____

Occupation: _____

Previous Occupations: _____

Presenting problem (be as specific as you can: when did it start, how does it affect you, etc.):

Estimate the severity of above problem: Mild Moderate Severe Very Severe

Previous Care:

Have you participated in psychotherapy before? Yes No

of months year(s) _____ (beginning-to-end) & estimated # of sessions _____

Type: Individual Couples Family Group Intensive Group Process/Seminar/Workshop

Name, degree, phone # of therapist, initial reason for therapy, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

Use other side of the page for more information about psychotherapists if necessary.

Medical doctor (name/phone): _____

Past/present medical care (major medical problems, psychiatric hospitalizations, surgeries, accidents, falls, illness):

Specify medication you are presently taking and for what. Please PRINT clearly:

Past and/or present drug/alcohol use/abuse (binge drinking, AA, NA, inpatient/outpatient treatments):

Are you presently feeling suicidal? Yes No Maybe

Suicide attempt(s) or violent behavior (describe: age(s), reason(s), circumstances, how, etc.):

Past and/or present self-regulating behaviors (cutting, binge eating, retail therapy, sexual acting out, etc.)

Relationship Status and History:

Single Partnered Married Divorced Widowed Live w/: Years: _____

Past & present marriage(s) or significant relationships (names, years together, & statement about the nature of the relationship, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

Present spouse/partner: Education: _____ Occupation: _____

Family Status and History:

Parents / Step-parents / Grandparents (name, occupation, personality, how does (s)he treat you, brief statement about the relationship, if dead: age and cause of death):

Father: _____

Mother: _____

Step-parents: _____

Grandparents: _____

Siblings (name, age, step siblings if any, brief statement about your relationship, if dead: age and cause of death):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Children (name, age, step children if any, brief statement about your relationship, if dead: age and cause of death)

- 1. _____
- 2. _____
- 3. _____

If parents divorced: Your age at the time: _____. Describe how it affected you at the time:

Family history of alcoholism, mental illness, or violence (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

Family medical history (describe any illnesses that run in the family: cancer, heart disease, epilepsy, autism, etc.):

Describe your childhood in general (relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

Self Care:

Friendships, community, cultural & spirituality (describe quality, frequency, activities, etc.):

Do you regularly engage in or practice:

- Yoga Meditation Spiritual Program Bodywork Martial Arts Exercise Program Nutritional Supplements Support Group Special Diet _____ Other _____

How would you rate the quality of your sleep? Poor Adequate Good Excellent

Please describe your sleep patterns (how many hours per night, quality, and problems if any)

How would you rate the quality of your eating habits? Poor Adequate Good Excellent

Please describe what you would eat in a typical day (include each meal and what you would typically eat)

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important hopes & dreams?

Are you involved in any current or pending civil or criminal litigation(s), lawsuit(s) or divorce or custody dispute(s)? (if yes, please explain):

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation.

Signed: _____ Date: _____