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BIOGRAPHICAL INFORMATION – INTAKE FORM

Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential.

NAME: _____ DATE OF BIRTH:_____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
MALE/FEMALE: _____ SOCIAL SECURITY #: _____
TELEPHONE: H:_____ W: _____ CELL: _____
EMAIL: _____ MAY WE CALL YOU AT HOME?: _____
RESPONSIBLE PARTY: _____
HIGHEST GRADE/DEGREE: _____ TYPE: _____
PERSON AND PHONE # TO CALL IN AN EMERGENCY:
_____
REFERRAL SOURCE:
_____
OCCUPATION (FORMER IF RETIRED):
_____
PRESENTING PROBLEM (PLEASE BE SPECIFIC; WHEN DID IT START AND HOW DID IT AFFECT YOU):
_____
_____
_____
ESTIMATE THE SEVERITY OF THE ABOVE PROBLEM: MILD ___, MODERATE _____, SEVERE _____
VERY SEVERE, _____

WHAT TYPE OF STRESSES DO YOU HAVE IN YOUR LIFE? _____
_____
_____
HAVE THERE BEEN ANY LOSSES AND/OR TRAUMAS YOU HAVE EXPERIENCED THAT STILL AFFECT YOUR LIFE?
_____
_____
MARITAL STATUS: _____, LIVE WITH SOMEONE: _____
PAST & PRESENT MARRIAGE(S): _____ HOW LONG? _____
_____
_____
PRESENT SPOUSE (IF MARRIED): _____

EDUCATION: _____
OCCUPATION: _____

CHILDREN/STEP/GRAND (NAME, AGE, AND A BRIEF STATEMENT ON YOUR RELATIONSHIP WITH THE PERSON).

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PARENTS/STEP-PARENT (NAME/AGES OR YEAR OF DEATH)
HOW WOULD YOU RATE YOUR RELATIONSHIP: 1-5 SCALE (1=DISTANT, 5=VERY CLOSE)
BRIEF STATEMENT OF THE RELATIONSHIP:
FATHER: _____
_____
_____
MOTHER: _____
_____
_____
STEP-PARENTS: _____
_____
_____
MEDICAL DOCTOR (S) (NAME, PHONE NUMBER): _____
_____
PAST/PRESENT MEDICAL CARE (MAJOR MEDICAL PROBLEMS, SURGERIES)
_____
_____
PLEASE SPECIFY ALL MEDICATIONS YOU ARE PRESENTLY TAKING AND FOR WHAT PURPOSE:
_____
_____

Current Use/Abuse/Treatments

Substance	Frequency	Amount
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Other		

Past Use/Abuse/Treatments

Substance	Frequency	Amount
Alcohol		
Tobacco		
Caffeine		
Marijuana		
Other		

SUICIDE ATTEMPT(S) (DESCRIBE YOUR AGE, REASONS, HOW, ETC.):

_____

_____

PAST/PRESENT PSYCHOTHERAPY (NAME OF THERAPIST, DATES, INITIAL REASON FOR THERAPY):

_____

_____

_____

DESCRIBE YOUR CHILDHOOD IN GENERAL (RELATIONSHIPS WITH PARENTS, SIBLINGS, OTHERS, SCHOOL, NEIGHBORHOOD, RELOCATIONS, ANY SCHOOL/BEHAVIORAL PROBLEMS, ABUSIVE/ALCOHOLIC PARENTS): _____

_____

_____

IF PARENTS ARE DIVORCED: YOUR AGE AT THE TIME: _____. DESCRIBE HOW IT AFFECTED YOU AT THE TIME: _____

_____