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Biographical Information Form - Adult

Please fill out this form as fully and openly as possible. All information is held in **strictest confidence** within legal limits. If certain questions do not apply to you, cross them out or write "N/A."

Today's Date: ______________________________

Name: ____ **Age**: ______ **Date of Birth:** _______________
Gender: Male / Female **Ethnicity**: ______________________
Highest Level of Education: __________________________ **Occupation**:_______________________________

Address: ____
(No P.O. Box) Street & Number City State Zip
Home Phone: ______________________ Message ok: Yes / No
Business Phone: ____________________ Message ok: Yes / No
Cell Phone: _________________________ Message ok: Yes / No

Present Relationship Status (check as many as apply):

___ Single, never married
___ In a relationship, if so, for how long:_______
___ Engaged to be married
___ Married now for first time, if so, for how long:_______
___ Married now after first time, if so, for how long:______
____ Domestic Partnership, if so, for how long:___________
____ Separated, if so, for how long ____________________
____ Divorced and not remarried, if so, for how long ______
____ Widowed, if so, for how long _____________________
____ Other: ____________________________________

Name of Spouse or Significant Other: _______________________________________ Age: ________________
His/Her Occupation: ________________________ His/Her highest level of education: _____________________

Names of Children	Age	Sex	Where living?	Names of Children	Age	Sex	Where living?
1)				4)			
2)				5)			
3)				6)			

Others living with you	Age	Sex	Relationship	Others living with you	Age	Sex	Relationship
1)				3)			
2)				4)			

Person to call in case of an emergency: ___________________________ **Relationship to you:** ______________
Emergency Contact Phone Number(s): ____

How did you hear about me (if referred, by whom?): ____
If referred, is it ok with you for me to thank your referral? Yes / No ____________
Client initial

Presenting Issue

What is/are your main reason(s) for seeking therapy & what is the motivation to seek therapy at this time?

____

____

____

When did this (these) problem(s) begin? ______________________________________

____

Under what conditions do your problems usually get worse?______________________________

____

Under what conditions are your problems usually improved?_____________________________

____

Counseling And Psychiatric History

Are you receiving counseling/therapy services at present? Yes_____ No_____ If yes, please briefly describe:____

____

Name of therapist: ______________________________Phone Number ____________________

Have you received counseling/therapy in the past? Yes_____ No_____ If yes, please briefly describe:

____

____

Names of Past therapist:

1) Name of therapist: ____________________________ Dates Seen: __________________
   Address: ___________________________________Phone Number: ________________
   Type of therapy: _______________ Focus of Therapy: ____________________________
   Was the therapy helpful? Please explain: ____
2) Name of therapist: ____________________________ Dates Seen: __________________
   Address: ___________________________________Phone Number: ________________
   Type of therapy: _______________ Focus of Therapy: ____________________________
   Was the therapy helpful? Please explain: ____
3) Name of therapist: ____________________________ Dates Seen: __________________
   Address: ___________________________________Phone Number: ________________
   Type of therapy: _______________ Focus of Therapy: ____________________________
   Was the therapy helpful? Please explain: ____

Has a mood or behavior altering drug/medication ever been prescribed for you? If so, what and when?

____

Have you ever been hospitalized? If so, when and for what? Please explain: ______________________

____

Has anyone in you family ever had a problem with mental illness? Please explain**:** _________________

____

Medical & Substance History

Primary Care Physician: ____

Address: ______________________________ Phone: ______________

What medications are you taking at present, and for what purpose?

Medication Dose Purpose Date Started Who is the prescribing physician?

1. ____
2. ____
3. ____

List any physical/medical problems you are having at present: (e.g., high blood pressure, headaches, dizziness, etc.):

____

____

List any other physical/medical problems you have experienced in the past:______________

____

When was your most recent complete physical exam?______________________

Results of physical exam: ____

How many visits to doctor in the past year:________ Sick days in the past year:_________

Have you ever had a seizure? No / Yes **Family History of seizures**? No / Yes

Have you ever been bitten by a tick? No / Yes **Anyone in your family bitten by a tick?** No / Yes

Sleep Habits: On average, how many hours of sleep do you get daily? _____ What time do you go to bed? _____

Do you have trouble falling asleep at night? No / Yes If yes, describe______________

Do you have trouble sleeping through the night? No / Yes If yes, describe______________

Do you have trouble waking in the morning? No / Yes If yes, describe______________

Eating Habits: Do you now, or have you ever, engaged in binge eating, purging, restricting food, compulsive exercising, or other compulsive eating behavior? If so, please explain: ______________

____

Have you gained/lost over ten pounds in the past year? Yes / No

If yes, was the gain/loss on purpose? Yes / No Please explain: ______________

Describe your appetite for the past 2-weeks: ____ Poor appetite ____ Average appetite ____ Large appetite

Alcohol, Drug, and Caffeine Use:

Do you use caffeine? (Include coffee, teas, sodas, chocolate, etc) Yes / No If yes, how much? __________

Do you smoke cigarettes? Yes / No If yes, What is your quantity & frequency of tobacco use? __________

Do you use alcohol? Yes / No If yes, What is your quantity & frequency of alcohol use? __________

If yes, have you ever tried to stop? Please explain: ______________________________

____

Do you use non-prescribed drugs or prescription marijuana? Yes / No

If yes, what drugs do you use?______________________________

If yes, how much do you use for each drug? ______________________________

If yes, what is your frequency of use?______________________________

If yes, have you ever tried to stop? Please explain: ______________________________

____

Have you ever been admitted to an alcohol or drug dependency program? If yes, when? __________

What was the outcome? ____

Has anyone in your family ever had a problem with substance use/abuse? Please explain: __________

____

Current Life Stressors & Functioning

Current life stressors:

____Legal ____Family Problems ____Unemployment ____Friendships ____Medical
____Financial ____Family Illness ____Job Related ____Life Transition ____Other:_______

Are you in an abusive relationship?
____Yes ____No ____Somewhat

	Very Much	**Much**	**Somewhat**	**A Little**	**No/None**
Do you feel you are a person of worth at least on an equal basis with others?	_______	______	_____	______	_____
How much enjoyment or pleasure are you currently getting out of living?	_______	______	_____	______	_____

< 1________2________3________4________5________6________7________8________9________10>
Barely Able to Function Severe Difficulty Moderate Difficulty Mild Difficulty Excellent Functioning

Please rate (from 1-10) how well you feel you are currently functioning in the following areas:

General Mood (depression, anxiety, etc): _______ Social Relationships: _______
Family Relationships/Home Life: ____ Work or School: _________

Please rate (from 1-10) how well you feel you were functioning one year ago in the following areas:

General Mood (depression, anxiety, etc): _______ Social Relationships: _______
Family Relationships/Home Life: ____ Work or School: _________

List your current main social difficulties:____

____

____

List your current main love and/or sex difficulties:____________________________________

____

____

List your current main difficulties at school or work:_________________________________

____

____

List your current main difficulties at home:____

____

____

Religious And Spiritual Practices

What is your present religious affiliation? ____

What was your religious affiliation(s) of your childhood? ________________________________

How important is religion in your life?

Unimportant			Average Importance		Extremely Important	
1	2	3	4	5	6	7

How important is spirituality in your life?

Unimportant			Average Importance		Extremely Important	
1	2	3	4	5	6	7

Do you desire to have your religious/spiritual beliefs and values incorporated into the counseling process?

Yes / No / Not sure If yes, please explain how you like them incorporated: ____________________

____

Are you currently using your religious or spiritual practices to help you with your problem? Yes / No

Is it helping? Please explain: ____

____

____

Strengths & Resources

List your five greatest strengths (how do you cope) when times are hard:

1)____
2)____
3)____
4)____
5)____

What makes you laugh? ____

____

Where and/or with whom do you feel safe? ____

Who do you turn to for advice & support? ____

What are you best at? ____

Thoughts

Please check how often the following thoughts have occurred to you in the past 6 months:

1)	Life is hopeless	____Never	____Rarely	____Sometimes	____Frequently
2)	I am lonely	____Never	____Rarely	____Sometimes	____Frequently
3)	No one cares about me	____Never	____Rarely	____Sometimes	____Frequently
4)	I am a failure	____Never	____Rarely	____Sometimes	____Frequently
5)	Most people don't like me	____Never	____Rarely	____Sometimes	____Frequently
6)	I want to die	____Never	____Rarely	____Sometimes	____Frequently
7)	I want to hurt someone	____Never	____Rarely	____Sometimes	____Frequently
8)	I am so stupid	____Never	____Rarely	____Sometimes	____Frequently
9)	I am going crazy	____Never	____Rarely	____Sometimes	____Frequently
10)	I can't concentrate	____Never	____Rarely	____Sometimes	____Frequently
11)	I am so depressed	____Never	____Rarely	____Sometimes	____Frequently
12)	God is disappointed in me	____Never	____Rarely	____Sometimes	____Frequently
13)	I can't be forgiven	____Never	____Rarely	____Sometimes	____Frequently
14)	Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
15)	I can't do anything right	____Never	____Rarely	____Sometimes	____Frequently
16)	People hear my thoughts	____Never	____Rarely	____Sometimes	____Frequently
17)	I have no emotions	____Never	____Rarely	____Sometimes	____Frequently
18)	Someone is watching me	____Never	____Rarely	____Sometimes	____Frequently
19)	I hear voices in my head	____Never	____Rarely	____Sometimes	____Frequently
20)	I am out of control	____Never	____Rarely	____Sometimes	____Frequently
21)	I want to hurt myself	____Never	____Rarely	____Sometimes	____Frequently
22)	Nothing makes me happy	____Never	____Rarely	____Sometimes	____Frequently

Have you ever thought about ending your life? Yes / No

If so, first time: ______________________________ Most recent time:____

Symptoms

Which of the following have you experienced in the past 12 months?

_____ aggression	_____ fatigue	_____ sexual difficulties
_____ alcohol abuse	_____ hallucinations	_____ sick often
_____ anger	_____ heart palpitations	_____ sleeping problems
_____ antisocial behavior	_____ high blood pressure	_____ speech problems
_____ anxiety	_____ hopelessness	_____ suicidal thoughts
_____ avoiding people	_____ impulsivity	_____ thoughts disorganized
_____ chest pain	_____ irritability	_____ trembling
_____ depression	_____ judgment errors	_____ withdrawing from people/activities
_____ disorientation	_____ loneliness	_____ worrying
_____ distractibility	_____ memory impairment	_____ other (specify):
_____ dizziness	_____ mood shifts	________________________________
_____ drug abuse	_____ panic attacks	________________________________
_____ eating disorder	_____ phobias/fears	________________________________
_____ elevated mood	_____ recurring thoughts	________________________________

Family History

Family Overview:

Mother's age: ____, if deceased, how old was she when she died? ____ How old were you when she died? ____

Father's age: _____, if deceased, how old was he when he died? _____ How old were you when he died? _____

If your parents are separated or divorced, how old were you when it happened?__________________________

Number of brother(s) ________ their ages _____ _____ _____ _____ _____ _____

Number of sister(s) _________ their ages _____ _____ _____ _____ _____ _____

I was child number ________ in a family of ________ children.

Were you adopted or raised with parents other than your natural parents? Yes___ No___
Who was your primary caretaker growing up? ____
Briefly describe your relationship with your brothers and/or sisters:____________________________________
____
____
____

Which of the following best describes the family in which you grew up?

WARM AND ACCEPTING				AVERAGE				HOSTILE AND FIGHTING
1	2	3	4	5	6	7	8	9

Which of the following best describes the way in which your family raised you?

ALLOWED ME TO BE VERY INDEPENDENT				AVERAGE				ATTEMPTED TO CONTROL ME
1	2	3	4	5	6	7	8	9

YOUR MOTHER (or female caregiver) **Name:** ____
Briefly Describe Your Mother: ____
____
____

How did she discipline you?____
____

How did she reward you?____
____

How much time did she spend with you when you were a child? _____ Much _____ Average _____ Little

Your mother's occupation when you were a child: ____

_____ Stayed home _____ Worked outside part-time _____ Worked outside full-time

How well did you get along with your mother when you were a child? _____ Poor _____ Average _____ Well

How do you get along with your mother now? _____ Poor _____ Average _____ Well
Did your mother have any problems that may have affected your childhood?
Yes ________ No _______ If Yes, please describe.________________________________
____

Is there anything unusual about your relationship with your mother?

Yes ________ No ________ If Yes, please describe. ____

____

____

Describe overall how your mother treated the following people as you were growing up:

(Circle one answer for each)

YOUR MOTHER'S TREATMENT OF:	Poor			Average			Excellent
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR FATHER	1	2	3	4	5	6	7

STEP-MOTHER (or mother substitute): (If more than one please write on each on the back side of this page.)

Name: ____________________________________

Briefly describe your stepmother:____

How did she discipline you? ____

How did she reward you?____

How much time did she spend with you when you were a child? _____ Much _____ Average _____ Little

Your mother's occupation when you were a child: ____

_____ Stayed home _____ worked outside part-time _____ worked outside full-time

How did you get along with your mother when you were a child? _____ Poor _____ Average _____ Well

How well do you get along with your mother now? _____ Poor _____ Average _____ Well

Did your stepmother have any problems that may have affected your childhood development? Yes ________ No _______ If Yes, please describe. ____________________________________

____

Is there anything unusual about your relationship with your stepmother?

Yes ________ No ________ If Yes, please describe). ____

____

Describe overall how your stepmother or mother substitute treated the following people as you were growing up:

(Circle one answer for each)

YOUR MOTHER'S TREATMENT OF:	Poor			Average			Excellent
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR FATHER	1	2	3	4	5	6	7

YOUR FATHER (or male caregiver): **Name:** ____

Briefly describe your father:____

____

How did he discipline you?____

____

How did he reward you?____

____

How much time did he spend with you when you were a child? _____ Much _____ average _____ little

Your father's occupation when you were a child:____

_____ Stayed home _____ worked outside part-time _____ worked outside full-time

How well did you get along with your father when you were a child? _____ Poor _____ average _____ well

How do you get along with your father now? _____ Poor _____ average _____ well

Did your father have any problems that may have affected your childhood development?
Yes________ No________ (If Yes, please describe)___________________________
____
____

Is there anything unusual about your relationship with your father? No ______ Yes ______
(If Yes, please describe)____
____
____

Describe overall how your father treated the following people as you were growing up: ***(Circle one answer for each)***

YOUR FATHER'S TREATMENT OF:	Poor		Average			Excellent	
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR MOTHER	1	2	3	4	5	6	7

YOUR STEPFATHER (or father substitute): If more than one stepfather, please write on each of them on the back of this page.

Name:____
Briefly describe your Stepfather:____
____

How did he discipline you?____
____

How did he reward you?____
____

How much time did he spend with you when you were a child? _____ Much _____ average _____ little

Your Stepfather's occupation when you were a child: _______________________________________
_____ Stayed home _____ worked outside part-time _____ worked outside full-time

How well did you get along with your stepfather when you were a child? _____ Poor _____ average _____ well

How do you get along with your stepfather now? _____ Poor _____ average _____ well

Did your Stepfather have any problems that may have affected your childhood development?
Yes________ No________ If yes, please describe. ______________________________
____
____

Is there anything unusual about your relationship with your stepfather? No ______ Yes __________________
(If Yes, please describe)____
____
____

Describe overall how your stepfather treated the following people as you were growing up: ***(Circle one answer for each)***

YOUR FATHER'S TREATMENT OF:	Poor		Average			Excellent	
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR MOTHER	1	2	3	4	5	6	7