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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 / Trans Male / Trans Female / Non-binary / Other / Decline to Answer
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 <u>at this time</u>?

_____
_____
_____
_____
_____

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

_____

Under what conditions do your problems usually get worse?_____

_____

Under what conditions are your problems usually improved?_____

_____

Symptoms

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

_____ aggression
_____ alcohol abuse
_____ anger
_____ anxiety
_____ avoidance behavior
_____ blackouts/time loss
_____ chest pain
_____ depression
_____ disorientation
_____ distractibility
_____ dizziness
_____ drug abuse
_____ eating issues
_____ elated mood
_____ fatigue
_____ flashbacks
_____ grief
_____ hallucinations
_____ homicidal ideation
_____ impulsivity
_____ irritability
_____ judgment errors
_____ loneliness
_____ memory impairment
_____ mood shifts (sudden)
_____ panic attacks
_____ phobias
_____ poor/low self-esteem
_____ self-harm
_____ sexual difficulties
_____ sick often
_____ sleeping problems
_____ somatic complaints (no medical cause)
_____ suicide attempt
_____ suicidal thoughts
_____ withdrawing from activities
_____ worrying
_____ other (specify):
_____
_____
_____
_____

Are you currently suicidal? Yes / No

Are you currently homicidal or wanting to seriously hurt another person? Yes / No

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: _____
   Type of therapy: _____ Focus of Therapy: _____
   Was the therapy helpful? Please explain: _____
2) Name of therapist: _____ Dates Seen: _____
   Type of therapy: _____ Focus of Therapy: _____
   Was the therapy helpful? Please explain: _____
3) Name of therapist: _____ Dates Seen: _____
   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: _____

_____

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

If so, first time: _____ Most recent time:_____

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 <u>currently functioning</u> 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 <u>functioning one year ago</u> 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:_____
_____
_____

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? _____

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: _____
_____
_____

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

<u>YOUR MOTHER</u> (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