Biographical Information Form – Adult

Instructions: to assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

1. Name:_____ 2. Age:_____ 3. Gender: ___M __F__Nonbinary ___
4. Address: _____City: _____State: _____Zip: _____
5. Weight:_____ 6. Height: _____ 7. Eye Color: _____8. Hair Color:_____ 9. Race: _____
10. Today's Date:_____11. Date of Birth:_____ 12. Years of Education:_____
13. Occupation: _____ 14. Home Phone:_____
15. Business Phone_____16. Cell Phone:_____
17. Email Address:_____
18. Present Marital Status:

____ never married ____ separated

____ engaged to be married ____ divorced and not remarried

____ married now for first time ____ widowed and not remarried

____ married now after first time ____ other (specify)_____

Name of Partner: _____Wk. Phone: _____

Cell Phone:_____

19. Are you living with your partner at present? Yes_____ No_____

20. Years married to present partner: _____

21. Are you currently in college? Yes_____ No _____

If so, where are you enrolled and when will you graduate? _____

If you have already graduated from college, what college did you attend and what degree did you receive?_____

Counseling History

22. Are you receiving counseling services at present? Yes_____ No _____

If yes, please briefly describe:_____

23. Have you received counseling in the past? Yes_____ No_____

If yes, please briefly describe (include your diagnosis and symptoms you were treated for): _____

_____

List previous therapist's names and length of treatment: _____

_____

_____

24. What is (are) your main reason (s) for this visit? _____

_____

25. How long has this problem persisted (from #24)? _____

_____

26. Under what conditions do your problems usually get worse? _____

_____

27. Under what conditions are your problems usually improved? _____

_____

28. How did you hear about this therapist and/or who referred you? _____

_____

Medical History

29. Name and address of your primary physician:

Physician's name: _____

Address:_____

30. List any major illnesses and/or operations you have had: _____

_____

31. List any physical concerns you are having at present: (e.g. high blood pressure, headaches, dizziness, POTS, etc.)_____

_____

32. List any other physical concerns you have experienced in the past: _____

_____

33. When was your most recent complete physical exam? _____

What were the results of the physical exam? _____

_____

34. On average, how many hours of sleep do you get daily? _____

35. Do you have trouble falling asleep at night? _____Yes _____No

If yes, describe:_____

36. Have you gained/lost over ten pounds in the past year?_____ Yes: ____No ____ gained _____ lost

If yes, was the gain/loss on purpose? _____Yes _____No

37. Describe your appetite (during the past week):

_____ poor appetite _____ average appetite _____large appetite

38. What medications (and dosages) are you taking at present, and for what purpose?

Medication Purpose

_____ _____

_____ _____

_____ _____

Use the back of the paper for additional medications……..

How much alcohol do you drink: _____day, _____month

Do you use any drugs that are not prescribed to you, such as marijuana, mushrooms, opiates, etc. If so how often and how much do you use? _____

_____

Have you ever been:

Physically abused: Yes_____ No_____ by who and at what age: _____

Emotionally abused: Yes _____ No _____ by who and at what age: _____

Sexually abused: Yes _____ No _____ by who and at what age: _____

Have you ever told someone about the abuse?

Who did you tell about the abuse?

Did you receive therapy for the abuse?

Reproductive History:

39. Number of previous pregnancies: _____

40. Number of live births: _____

41. Number of miscarriages: _____

42. Number of therapeutic abortions: _____

Religious Concerns

43. What is your present religious affiliation

_____ Catholic

_____ Jewish

_____ Protestant (specify denomination if any)_____

_____ None, but I believe in God

_____ Atheist or agnostic

__Other (please specify)_____

44. How important is religious commitment to you?

Unimportant Average importance Extremely important

1 2 3 4 5 6 7

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

____ Yes ____ No ____ Not sure (If yes, please explain)_____

_____

Family Information

46. Mother's age:_____ If deceased, how old were you when she died? _____

47. Father's age:_____ If deceased, how old were you when he died? _____

48. If your parents are separated or divorced, how old were you then? _____

49. Number of brothers: _____ Their ages: _____ _____ _____ _____ _____

50. Number of sisters: _____ Their ages: _____ _____ _____ _____ _____

51. I was child number _____in a family of _____ children.

52. Were you adopted or raised with parents other than your natural parents? ____ Yes ____ No

53. Briefly describe your relationship with your brothers and/or sisters: _____

_____

_____

54. 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

55. 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 mother substitute)

56. Briefly describe your mother: _____

_____

57. How did she discipline you? _____

58 How did she reward you? _____

59. How much time did she spend with you when you were a child?

_____ much _____average _____Little

60. Your mother's occupation when you were a child:

_____ stayed home _____worked outside part-time _____worked outside full-time

61. How did you get along with your mother when you were a child?

_____ poorly _____average _____well

62. How do you get along with your mother now?

_____ poorly _____average _____well

63. Did you mother have any problems (e.g. alcoholism, violence, etc) that may have affected your childhood development?

_____ Yes _____ No

(If yes, please describe)_____

_____

64. Has your mother ever been in counseling? If so, for what reason?

_____

65. Is there anything unusual about your relationship with your mother?

_____ Yes _____ No (If yes, please describe)_____

_____

66. 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
You	1	2	3	4	5	6	7
Your family	1	2	3	4	5	6	7
Your father	1	2	3	4	5	6	7

YOUR FATHER (or father substitute)

67. Briefly describe your father: _____

_____

68. How did he discipline you? _____

_____

69. How did he reward you? _____

_____

70. How much time did he spend with you when you were a child?

_____ much _____average _____Little

71. Your father's occupation when you were a child: _____

_____ stayed home _____worked outside part-time _____worked outside full-time

72. How did you get along with your father when you were a child? _____

_____ poorly _____average _____well

73. How do you get along with your father now?

_____ poorly _____average _____well

74. Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development?

_____ Yes _____ No

(If yes, please describe)_____

_____

75. Has your father ever been in counseling? If so, for what reason?

_____

76. Is there anything unusual about your relationship with your father?

_____ Yes _____ No (If yes, please describe)_____

_____

77. 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
You	1	2	3	4	5	6	7
Your family	1	2	3	4	5	6	7
Your Mother	1	2	3	4	5	6	7

RELATIONSHIP WITH YOUR SPOUSE/SIGNIFICANT OTHER:

78. Briefly describe your spouse/significant other: _____

_____

79. How do you get along with your spouse/significant other? _____

_____

80. Does your spouse/significant other have any problems which he may or may not be seeking help for (e.g. alcoholism, violence, depression, anxiety, etc.) _____

_____

81. Is your spouse/significant other currently in counseling? _____Yes _____No

82. Have they ever been in counseling? _____Yes _____No

RELATIONSHIP WITH YOUR CHILDREN:

83. Please give us your children's names and ages:

_____

_____

_____

_____

84. Briefly describe your children: _____

_____

_____

85. How do you get along with your child/children: _____

_____

_____

86. Do your children have any issues that are of concern? _____

In school:_____

At home: _____

Socially: _____

EXTENDED FAMILY HISTORY:

Please indicate with a checkmark whether there is any family history of any of the following difficulties. Include parents, siblings, grandparents, aunts, uncles, cousins. If present, please specify the relationship:

Difficulty	**Relationship**
_____ Mental Retardation	_____
_____ Attention Deficit Disorder or Attention Problems	_____
_____ Tourette's Syndrome or Tic Disorder	_____
_____ Learning Problems/Failure	_____
_____Communication Disorder	_____
_____ Autism	_____
_____ Anxiety Problems	_____
_____ Obsessive Compulsive/Repetitive Behaviors	_____

_____ Depression _____

_____ Suicide Attempt _____

_____ Sexual or Physical Abuse _____

_____ Drug Abuse _____

_____ Alcoholism _____

_____ Legal Difficulties _____

_____ Schizophrenia _____

_____ Psychiatric Hospitalizations _____

_____ Use of Psychiatric Medication _____

_____ Thyroid Problems _____

_____Genetic/Metabolic Disorders _____

_____ Other Mental Health Concern _____

Additional Comments:

Please use the space below to describe any other information you feel would be helpful to us in understanding your child and your concerns.

_____

_____

Thoughts and Behaviors

87. Please check how often the following thoughts occur to you:

Life is hopeless	____Never	____Rarely	____Sometimes	____Frequently
I am lonely	____Never	____Rarely	____Sometimes	____Frequently
No one cares about me	____Never	____Rarely	____Sometimes	____Frequently
I am a failure	____Never	____Rarely	____Sometimes	____Frequently
Most people don't like me	____Never	____Rarely	____Sometimes	____Frequently
I want to die	____Never	____Rarely	____Sometimes	____Frequently
I want to hurt someone	____Never	____Rarely	____Sometimes	____Frequently
I am so stupid	____Never	____Rarely	____Sometimes	____Frequently
I am going crazy	____Never	____Rarely	____Sometimes	____Frequently

I can't concentrate ____Never ____Rarely ____Sometimes ____Frequently

I am so depressed ____Never ____Rarely ____Sometimes ____Frequently

God is disappointed in me ____Never ____Rarely ____Sometimes ____Frequently

I can't be forgiven ____Never ____Rarely ____Sometimes ____Frequently

Why am I so different ____Never ____Rarely ____Sometimes ____Frequently

I can't do anything right ____Never ____Rarely ____Sometimes ____Frequently

People hear my thoughts ____Never ____Rarely ____Sometimes ____Frequently

I have no emotions ____Never ____Rarely ____Sometimes ____Frequently

Someone is watching me ____Never ____Rarely ____Sometimes ____Frequently

I hear voices in my head ____Never ____Rarely ____Sometimes ____Frequently

I am out of control ____Never ____Rarely ____Sometimes ____Frequently

People hear my thoughts ____Never ____Rarely ____Sometimes ____Frequently

I have no emotions ____Never ____Rarely ____Sometimes ____Frequently

Someone is watching me ____Never ____Rarely ____Sometimes ____Frequently

I hear voices in my head ____Never ____Rarely ____Sometimes ____Frequently

I am out of control ____Never ____Rarely ____Sometimes ____Frequently

Do you have frequent thoughts, images, or urges that you find disturbing?
____Never ____Rarely ____Sometimes ____Frequently

Do you do mental, or physical behaviors or acts to try to neutralize those thoughts, images, or urges?
____Never ____Rarely ____Sometimes ____Frequently

Do those mental or physical behaviors or acts interfere with your day-to-day functioning?
____Never ____Rarely ____Sometimes ____Frequently

Have others commented that it takes you longer to do things than others?
____Never ____Rarely ____Sometimes ____Frequently

Do you get easily frustrated at people when they will not answer questions that they have already answered for you?
____Never ____Rarely ____Sometimes ____Frequently

Do you spend a lot of time trying to make sure that everything is just right, that no one is disappointed with you, or that you would not be responsible for something going wrong?
____Never ____Rarely ____Sometimes ____Frequently

Please comment (e.g. examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary:

_____

_____

_____

Symptoms

88. Check the behaviors and symptoms that occur to your more often than you would like them to take place:

____ aggression	_____ fatigue	_____sexual difficulties
____ alcohol dependence	_____ 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 pains	_____ irritability	_____ trembling
____ depression	_____judgment errors	_____ withdrawing
____ disorientation	_____ loneliness	_____ worrying
____ distractibility	_____ memory impairment	_____ other (specify)
____ dizziness	_____ mood shifts	_____
____ drug dependence	_____ panic attacks	_____
____ eating disorder	_____ phobias/fears	_____
____ elevated mood	_____ recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g. socially, emotionally, occupationally, physically, etc.) Use the back of this sheet if necessary.

_____

_____

_____

_____

89. List your five greatest strengths:

_____

_____

_____

90. List your five greatest weaknesses:

_____

_____

_____

_____

91. List your main social difficulties: _____

_____

92. List your main love and sex difficulties: _____

_____

_____

93. List your main difficulties at school or work: _____

_____

_____

94. List your main difficulties at home: _____

_____

_____

95. List your behaviors that you would like to change: _____

_____

_____

96. What are your biggest fears?

_____

_____

97. Name 5 things you did as a child that you loved.

_____

_____

98. Is there any activity you do that makes you forget what time it is?_____

_____

99. If you could wave a magic wand over your life, what would you wish for?_____

_____

100. How do you usually feel (what emotions do you experience)?_____

_____

101. How would you like to feel?_____

_____

102. What would you do if you knew you would not fail?_____

_____

103. What do other people always say about you? Who are you to others? _____

_____

104. What do you want people to say about you when you are gone? _____

_____

105. What is important to you right now? _____

_____

Additional information that you believe would be helpful: _____

_____

_____

_____

Please return this and other assessment materials to this office at least two days before your next appointment.