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Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. Please print or write clearly and bring it with you to the first session. Feel free to use the blank side of the page, or to add more pages if you need more for any information requested below.

NAME_____MALE/FEMALE_____TODAY'S DATE_____
DATE OF BIRTH_____PLACE OF BIRTH_____AGE_____
ADDRESS_____

TELEPHONE: H_____CELL_____WORK_____
FAX_____
FOR ROUTINE MESSAGES: Phone #_____Email_____
FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____
Email_____

HIGHEST GRADE/DEGREE_____TYPE OF DEGREE:_____

PERSON TO CALL IN EMERGENCY_____
EMERGENCY PERSON'S PHONE NUMBER_____

REFERRAL SOURCE_____

OCCUPATION (former, if retired)_____

PRESENTING PROBLEM (Be as specific as you can: when it started, how it affects you, etc.)_____
_____
_____
_____
_____
_____
_____
_____

Estimate the severity of above problem: Mild___ Moderate___ Severe___ Very severe___

MARRIED___LIVE WITH SOMEONE___NAME_____
HOW LONG WITH THIS PERSON_____
_____

PAST & PRESENT MARRIAGES (years together, names & statement about the nature of the relationship(s); i.e., friendly, physically/emotionally abusive, loving, hostile, close/distant, etc.)

PRESENT SPOUSE/PARTNER: Education_____ Occupation_____
Children/Step/Grand (names/ages)
_____
_____

Brief statement on your relationship with SPOUSE/PARTNER

PARENTS/STEP-PARENT(S)(Name/age, year/cause of death, occupation, personality, how did s/he treat you? Brief statement about the relationship)

Father_____

Mother_____

Siblings (Name/age, if dead: age and cause of death/brief statement about the relationship)

MEDICAL DOCTORS (name(s) & phone number(s))

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness)

SPECIFY MEDICATION you are taking presently and for what. PRINT CLEARLY.

PAST/PESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, other treatments)

SUICIDE ATTEMPT(S) OR VIOLENT BEHAVIOR (Describe: ages, reasons, circumstances, how, etc.)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc.)

PAST/PRESENT PSYCHOTHERAPY (Specify: month & year(s) (beginning & end), estimated number of sessions, name, degree, phone and address, initial reason for therapy, Individual, Couple and/or Family Therapy, medication, brief description of the relationship and how helpful it was, how and why it ended)

_____
_____

(Use other side of page for more information about therapists.)

FRIENDSHIPS, COMMUNITY AND SPIRITUALITY: (Describe quality, frequency, activities, etc.) _____

DESCRIBE YOUR CHILDHOOD BELOW IN GENERAL: (Relationships with parents, siblings, others, school, neighborhood, relocations, any school and/or behavior problems, abusive/alcoholic/drug addicted parent(s), etc.)
IF PARENTS DIVORCED: Your age at the time:_____. Describe also below how it affected you at the time.

_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE: (including suicide, depression, hospitalizations in mental institutions, abuse, etc.)_____

_____
_____
_____
_____
_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATIONS, LAWSUITS OR DIVORCE OR CUSTODY DISPUTES? (If you answer Yes, please explain.)

_____
_____
_____
_____
_____

WHAT GIVES YOU THE MOST PLEASURE IN LIFE?

_____
_____
_____
_____
_____

WHAT ARE YOUR MAIN WORRIES AND FEARS?

_____
_____
_____
_____
_____

WHAT ARE YOUR MOST IMPORTANT HOPES OR DREAMS?

_____
_____
_____
_____
_____

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.