

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 as outlined in the Office Policy form. If you do not desire to answer any question, merely write "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: ____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: H: _____ W: _____ CELL: _____

Would you like to be kept up to date with articles and information regarding healthy living? If so, please include an email address:

EMAIL: _____

PERSON AND PHONE # TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATION (former. if retired): _____

PRESENTING PROBLEM (be as specific as you can: When did it start, how does it affect you...):

Estimate the severity of the above problem: Mild __, Moderate __, Severe __, Very severe __

CURRENT: Marital status: __ Live with someone: __ Name: _____ Years: __

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. _____
2. _____
3. _____

4. _____

5. _____

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

Father: _____

Mother: _____

Step-parents _____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL DOCTOR/S (name /phone): _____

May Dr. McClellan fax, call and coordinate your care with your Dr.?

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

Specify all MEDICATION you are presently taking and for what. PRINT clearly:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, 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):

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

DO YOU EXERCISE REGULARLY? (Please describe) _____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

3. USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time:

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

What gives you most joy or pleasure in your life: _____

What are your main worries and fears: _____

What are your most important hopes or dreams: _____

Thank You