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Biographical Information – Intake Form

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. If you do not wish to answer a question, simply write, "Do not care to answer."

Name: _____ Date: _____

Date & Place of Birth: _____ Age: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone #: H: _____ Cell: _____ Work: _____

Ok to Leave Message? Yes____ No____ Email: _____

Military Service: Yes____ No____ Branch/Job: _____

Ethnicity: _____ Marital Status: _____ Education/Degree: _____

Occupation: _____ School Currently Attending: _____

Employer: _____ How Long at This Employer:_____

Person & Phone # to Call in Emergency: _____

If Client is a Minor, Name of Parent/Guardian: _____

Referred by: _____

Insurance Company: _____

Insurance ID#: _____ Co-Pay: _____

Name of Insured Person (if different from above): _____

Address:_____

Social Security #: _____ Date of Birth: _____

Relationship to Client: _____

Are You Court-Ordered To Participate In Counseling? Yes No

Are You Involved In An Active CPS Case? Yes No

Are You Currently Involved In Any Civil Or Criminal Lawsuit/Litigation, Divorce Or Custody Disputes? Yes No

If Yes, Please Explain:

_____

_____

Presenting Problem (be as specific as you can, e.g. when it started, how it affects you):

_____

_____

_____

Current Spouse/Partner:_____ Occupation: _____

Past & Present Marriage/s (Names, Dates, Years together):

_____

_____

Children/Step-Children (Names/Ages):

_____

_____

Persons Currently Living With You:

_____

_____

Primary Physician/s (Name, Phone and Address):

_____

_____

Past/Present Medical Care (Major Medical Problems, Surgeries, Accidents, Illness, etc.):

_____

_____

_____ Date of last Physical:_____

Specify all Medication you are presently taking and for what. Print Clearly:

Medication:_____ Dosage: _____ Start Date:_____ Purpose: _____

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Medication:_____ Dosage: _____ Start Date:_____ Purpose: _____

Medication:_____ Dosage: _____ Start Date:_____ Purpose: _____

Allergies And Drug Reactions:_____

_____

Past/Present Drug/Alcohol Use/Abuse (Type of Drug, Amount, Treatments):

_____

_____

Suicide Attempt/s or Violent Behavior, Hospitalization/s (Describe: Ages, Reasons, Circumstances, How, etc.)

_____

_____

_____

Previous Mental Health Providers (Therapists, Psychiatrists, School Counselors):

Dates Provider's Name & Tel. # Problem(s) Addressed

_____

_____

_____

_____

Family-Of-Origin History:

Relative	Current Age (or age at death)	Illnesses (or cause of death, if deceased)	Education	Occupation
Father				
Mother				
Stepparents				

Grandparents				
Brothers				
Sisters				

If Parents Divorced: Your Age at the Time: _____

Do You Have Any Relatives That Have or Had Serious Mental/Emotional Problems or Alcohol/Drug Problems? If so, Please List:

Relationship	Diagnosis	# of Hospitalizations

What are your main worries and fears? _____

_____

_____

What caused you to seek treatment at this time? _____

_____

_____

What do you hope to gain from therapy? _____

_____

_____

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.

Current Problems or Symptoms

- Headaches
- Dizziness
- Stomach trouble
- Bowel trouble
- Back pain
- Tremors or tics
- Other physical problems:

  _____

- Can't get to sleep
- Nightmares
- Trouble concentrating
- Memory problems
- Worry a lot

- Can't make decisions
- Tense/unable to relax
- Panicky feelings
- Unreasonable fears
- Fear of losing self-control

- Strange or unusual thoughts
- Hallucinations
- Repetitive thoughts/acts
- Feel others try to harm you
- Ready to explode
- Thoughts about harming someone
- Excessive use of alcohol/drugs

- Waking up at night or in the early morning & unable to return to sleep
- Loss of appetite
- Weight loss
- Weight gain
- Unable to enjoy life
- Decreased sex drive
- Feel worthless
- Feel hopeless/helpless
- Thoughts of suicide
- No energy
- Sadness or depression
- Have withdrawn from others

- Increased sex drive
- Increased energy
- Decreased need for sleep

- Family conflict
- Work problems
- Problems with friends
- Feel very shy or afraid to stand up for your rights

- Other: _____

  _____