ADULT 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 Informed Consent form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any questions, 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: ____**AGE**: __________

ADDRESS: ____

TELEPHONE: Home: _________________________ **Cell**: ____________________**Other**: ______________

FOR ROUTINE MESSAGES: Phone # ____________________ E-mail: ______________________________

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone#__________________ E-mail: ___________________

CURRENT: Marital status: __________Live with someone: _______Name: ____________Years: ______

EDUCATION HISTORY: ____

HIGHEST GRADE/DEGREE: _______________________ **TYPE OF DEGREE**: ___________________________

OCCUPATION (former, if retired): ____

EMPLOYMENT HISTORY: ____

PERSON & PHONE NO. TO CALL IN EMERGENCY: ____

REFERRAL SOURCE: ____

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

____

____

Estimate the severity of above problem (circle): Mild - Moderate - Severe - Very severe

MEDICAL DOCTOR/S (name/phone): ____

____

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

____

____

SPECIFY MEDICATION you are presently taking and for what. Please PRINT clearly:

____

____

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, diabetes, etc.):

____

____

SPIRITUALITY (describe quality, frequency, activities, etc.):

____

____

PAST/PRESENT Mental Health Treatment: (specify: month & year(s) beginning to end; estimate number of sessions; name, degree, address and phone number of therapist(s); initial reason for therapy; Individual/Couple/Family/Group; medication prescribed; brief description of the relationship with therapist and how helpful it was, and why it ended):

1.____

____

USE THE TOP OF PAGE 3 AND/OR BACKSIDE IF NEEDED TO INCLUDE MORE INFORMATION ABOUT PSYCHOTHERAPISTS

2. ____

____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, peers, 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

____

____

SUPPORT SYSTEM: (Do you feel you have adequate support from family/friends, etc): Yes/No – Explain:

____

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 LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTES? (If you answer YES, please explain):

____

____

What gives you the most joy or pleasure in life?

____

____

What are your main worries or fears?

____

____