

Case #: _____

DX: _____

Biographical Information Form – Adult

To assist us in providing services to you, please complete this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. **If certain questions do not apply, leave them blank.** Some of the information is required by our accrediting and licensing agencies. **If you need help completing this form, please do not hesitate to ask.** Thank you for your cooperation.

Today's Date: _____ Birth Date: _____ Social Security #: _____

Medicaid #:-----

Name: _____ Age: _____ Gender: M F Race/Ethnicity: _____

Mailing Address: _____

Physical Address: (if different) _____

County: _____ City: _____ State: _____ Zip: _____

Do you live in a House Apartment Mobile Home Other _____

We may need to call you to remind you of an appointment or to change an appointment.

May we leave a message? Yes No (Please circle)

What is the best number to leave a message and contact you? _____

Annual Household Income: _____

Who currently lives in your household?

<u>Name</u>	<u>Date of birth</u>	<u>Age</u>	<u>Relationship</u>	<u>Gender</u>

Are you currently receiving counseling services elsewhere? Yes No

If yes, please describe with whom and the reason: _____

What is/are the main reason for this visit? _____

How long has this problem persisted? _____

Under what conditions is it usually worse? _____

Under what conditions is it usually better? _____

SYMPTOMS

Please indicate the severity of the following symptoms. If a symptom does not occur, you may leave it blank. Please use the following scale to rate the severity of each:

1 = minimal/rare 2 = mild/occasional 3 = moderate/frequent

- | | | |
|-------------------------------------|---------------------------------------|-----------------------------|
| _____ aggressive behavior | _____ general lack of expression | _____ Panic attacks |
| _____ alcohol dependence | _____ hallucinations | _____ phobias/fears |
| _____ anxiety | _____ heart palpitations | _____ recurring thoughts |
| _____ argumentative behavior | _____ high blood pressure | _____ sexual difficulties |
| _____ chest pain | _____ hopelessness | _____ sick often |
| _____ depressed mood | _____ impulsive behavior | _____ Sleep problems |
| _____ diminished social interaction | _____ irritability | _____ speech problems |
| _____ disorientation | _____ judgment errors | _____ suicidal thoughts |
| _____ distractibility | _____ lack of pleasure in | _____ tearfulness |
| _____ dizziness | _____ previously enjoyable activities | _____ thoughts disorganized |
| _____ drug use | _____ loneliness | _____ trembling |
| _____ eating disorder | _____ manic episodes | _____ work problems |
| _____ elevated mood | _____ memory impairment | _____ worrying |
| _____ fatigue | _____ mood shifts | _____ other: |

OCCUPATIONAL

Current means of financial support (check all that apply):

- Self Family Parents Spouse Children Retirement benefits Welfare Disability

Employment Status: employed full-time part-time unemployed disabled retired student

Current employer: _____ Phone: _____

Your current position: _____ Date Began: _____

YOUR CHILDREN

<u>Name</u>	<u>Male/Female</u>	<u>Age</u>

Who has custody of your children? _____

Are there custody issues? Yes No If yes, please explain. _____

FAMILY HISTORY

Are your parents: Married to each other Never married to each other
 Separated Year: _____ Divorced Year: _____
 Mother Remarried Father remarried

Were you reared with someone other than your parents? Yes No If yes, who? _____

How many siblings do you have? _____

Where are you in birth order (i.e. first, second, youngest, etc.)? _____

Please describe family relationships:

Past: _____

Present: _____

MARITAL/RELATIONSHIP HISTORY

Current Status: Single Separated Widowed
 Married Divorced Re-married

Please described your current marital or other significant relationship. _____

How satisfied are you in your current relationship?

Not at all Somewhat Extremely
1 2 3 4 5 6 7 8 9 10

PREVIOUS MARRIAGES/SIGNIFICANT RELATIONSHIPS

Relationship Dates Why Relationship Ended

SEXUAL HISTORY

Please indicate your sexual orientation. Heterosexual Homosexual Bi-sexual Unsure

Please describe your sexual history: _____

Do you have any sexual problems: YES NO

ABUSE HISTORY

Have you been a victim of any of the following types of abuse? If yes, please indicate by whom, the duration, and your age at the time of the abuse.

		<u>By Whom?</u>	<u>Duration</u>	<u>Your Age</u>
Physical Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Sexual Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Emotional Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____
Neglect/Abandonment	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____

Have you ever abused anyone? Yes No

If yes, please describe. _____

Have you ever been a victim of ANY other crime? Yes No

If yes, please describe. _____

Is there a family history of:

- Substance abuse Yes No Describe _____
- Suicide Yes No Describe _____
- Violence Yes No Describe _____
- Psychiatric Problems Yes No Describe _____
- Criminal Activity Yes No Describe _____

SUBSTANCE USE/HABITUAL BEHAVIOR

Do you use nicotine? Yes No Type: Cigarettes Cigars Smokeless

How long have you used nicotine? _____ How much per day? _____

Do you use alcohol? Yes No If yes, how frequent? _____

How much each time? _____

Type of use: Social Recreational Abusive Problematic Addicted

If you do not currently use alcohol have you in the past? Yes No If yes, how frequent? _____

How much each time? _____

Type of use: Social Recreational Abusive Problematic Addicted

Do you currently or have you in the past used street drugs or abused prescription drugs? Yes No

Details: _____

Do you have any other addictive or compulsive behaviors (eating, gambling, etc.)? _____

MEDICAL HISTORY

Primary care physician: _____

Address: _____

Are you under the care of a psychiatrist: Yes No If so, whom: _____

Other important healthcare providers: _____

Please list any medical conditions? _____

HOSPITALIZATIONS (PHYSICAL OR MENTAL HEALTH)

<u>Hospital</u>	<u>Dates</u>	<u>Reason</u>

OUTPATIENT MENTAL HEALTH TREATMENT

<u>Facility/Therapist</u>	<u>Dates</u>	<u>Reason</u>

Allergies: _____

MEDICATIONS

<u>Medication</u>	<u>Dose</u>	<u>Reason</u>	<u>Prescribing Physician</u>

EDUCATION

Highest educational level reached: _____

Official school classification (check all that apply):

- | | | |
|----------------------------------------------|---------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Regular classes |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Visually impaired | <input type="checkbox"/> Special education |
| <input type="checkbox"/> Behavior disorder | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Honors |
| <input type="checkbox"/> Other _____ | | |

Regarding **education**, please describe any problems you had: _____

LEGAL HISTORY

Probation/Parole officer: _____ Phone: _____

Please indicate dates

Pending charges: _____

Arrests: _____

Convictions: _____

RELIGIOUS/SPIRITUAL CONCERNS

What is your religious preference? _____

How important is spirituality/religion in your life?

- | | | | | | | | | | |
|------------|---|---|---|----------|---|---|---|---|-----------|
| Not at all | | | | Somewhat | | | | | Extremely |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Do you have any concerns related to spirituality or religion? _____

Is there anything else you would like the counselor to know that has not already been covered?