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CLIENT INFORMATION

Please fill out this biographical background form as completely as possible. All information is confidential as outlined in the Client Agreement and Notification form. If you do not desire to answer any question, merely write, "Prefer not to answer." Please print or write as clearly as possible.

Date: _____ **SS#**: _____-_____-_____

Name: _____ **Sex: Male** _____ **Female** _____

Date of Birth: _____ **Place of Birth:**
_____

Years in the USA: _____ **Ethnicity/Cultural Identity**: _____ **Gender/Sexual Identification**: _____

Relationship status: _____ Duration: _____ Live Together? Yes ___ No ___ **Number of Children** ____

Home Address: _____

_____

May I write you at your home address? Yes ___ No ___

Employer and Address: _____

_____

May I write you at your work address? Yes ___ No ___

Home Phone: _____ O.K. to leave detailed message? Yes___ No ____

Office Phone: _____ O.K. to leave detailed message? Yes___ No ____

Cell Phone: _____ O.K. to leave detailed message? Yes___ No ____

Email: _____ O.K. to email you? Yes___ No ____

Education Level: _____ **Occupation/Major** (former, if retired): _____

Referred by: _____

Will you be using insurance? Yes ___ No ___ **Insurance Co**:
_____

If spouse's/family member's policy, please indicate name, date of birth, address and employer:_____
_____
_____

Psychotherapy History: (therapist name, reason for therapy, Indiv/Couple/Family/Group, duration, how it ended):

Are you currently seeking professional counseling/therapy elsewhere? Yes ____ No ____

If so, please explain: _____

Prior suicide attempts/
When?

Prior Psychiatric Hospitalizations/When?

Please list your use of alcohol or illicit drugs, including amounts and frequency

Drug	Amount	Frequency

Have you ever been treated for chemical dependency/substance abuse? _____ If yes, when, where, and for how long?

Do your family or friends feel you have a problem with substance abuse?

What are your strengths/abilities?

Current Support (Friendships, Community, Spirituality): _____

Please indicate any individual or family history you feel may be relevant: _____

Please briefly describe the concerns that bring you here and your goals for therapy:

_____

_____

_____

_____

Please check any of the following items which concern you:

_____ Life transitions
_____ Self-esteem, self-confidence
_____ Cultural concerns
_____ Stress and coping
_____ Sleep problems
_____ Loneliness, homesickness
_____ Eating or appetite problems
_____ Health problems
_____ Procrastination/motivation problems
_____ Sexual concerns
_____ Alcohol or drug problems
_____ Traumatic experience
_____ Depression, feeling blue
_____ Suicidal feelings or behaviors
_____ Identity concerns
_____ Substance abuse
_____ Career/School choice or transition
_____ Stress in the workplace/school
_____ Anxiety, nervousness, fears
_____ Shyness, being assertive
_____ Physical stress (headaches, stomach pains, muscle tension, etc.)
_____ Relationship/marital concerns
_____ Physical/Sexual abuse, incest, or rape survivor
_____ Angry, hostile feelings
_____ Family conflict, generational differences
_____ Friendship conflicts
_____ Relationship with romantic partner
_____ Homicidal feelings or behaviors
_____ Self-control or impulse control
_____ Loss of significant person
_____ Other: _____

Please list any family history of mental health problems, mental health treatment including psychiatric hospitalizations, and substance abuse/chemical dependency:

_____

_____

Your physical and emotional health are highly interdependent. To help me understand you and your concerns, please provide the following:

Physician's Name, Contact Information, and Date of Last Exam: _____

_____

Are you currently being treated for any medical conditions? Yes ____ No ____

If yes, what are you being treated for? _____

Describe any medical conditions/health concerns/injuries/surgeries:

_____

_____

Do you have any difficulties sleeping? If yes, please explain:

_____

Smoker: **(Present)** **Yes____ No____ Daily amount_____How long_____**
(Past) **Yes____ No____ Daily amount_____ How long_____**

Exercise: **None _____ Some _____ Frequent_____**

Identify type and frequency_____

Sexual Functioning: Adequate ____ Inadequate/Impaired _____
Please specify
_____

Any additional pertinent health history not mentioned above:
_____
Please list any prescribed or non-prescribed medications or supplements you are currently taking:

Medication/Supplement	Dosage	Condition	Prescribing Physician

Person to contact in case of emergency:

Name _____ **Relationship**
_____

Home/Cell Phone _____ **Work Phone**
_____

Signature _____
Date _____

***Your signature will be considered your permission to contact named person in case of emergency.**