

Biographical Information

CLIENT NAME: _____	DATE OF BIRTH: _____	AGE: _____
THERAPIST NAME: _____	PERSON COMPLETING THIS FORM: _____	

Symptoms:

Click the box beside each concern experienced recently:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep problems	<input type="checkbox"/> Thoughts of suicide
<input type="checkbox"/> Panic	<input type="checkbox"/> Unusual thoughts	<input type="checkbox"/> Anger outbursts	<input type="checkbox"/> Changes in weight
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Memory problems	<input type="checkbox"/> Sexual problems	<input type="checkbox"/> Relationship difficulties
<input type="checkbox"/> Treated unfairly	<input type="checkbox"/> Frequent pain	<input type="checkbox"/> Low energy	<input type="checkbox"/> Concentration problems
<input type="checkbox"/> Restlessness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Legal difficulties
<input type="checkbox"/> Drug use	<input type="checkbox"/> Drinking problem	<input type="checkbox"/> Boredom	<input type="checkbox"/> Hopelessness
<input type="checkbox"/> Stress	<input type="checkbox"/> Shyness	<input type="checkbox"/> Work problems	<input type="checkbox"/> Confusion
<input type="checkbox"/> Guilt feelings	<input type="checkbox"/> Suspicion	<input type="checkbox"/> Loneliness	<input type="checkbox"/> Thoughts of hurting others
<input type="checkbox"/> Compulsions	<input type="checkbox"/> Worry	<input type="checkbox"/> Money problems	<input type="checkbox"/> Difficulty with decisions
<input type="checkbox"/> Specific fears	<input type="checkbox"/> Mourning	<input type="checkbox"/> Physical illness	<input type="checkbox"/> Poor motivation
<input type="checkbox"/> Feeling abandoned	<input type="checkbox"/> Meaninglessness	<input type="checkbox"/> Perfectionism	<input type="checkbox"/> Unusually sensitive
<input type="checkbox"/> Irritability	<input type="checkbox"/> Social withdrawal	<input type="checkbox"/> Feeling misunderstood	<input type="checkbox"/> Troublesome thoughts
<input type="checkbox"/> Religious concerns	<input type="checkbox"/> Disappointment	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Hearing strange voices
<input type="checkbox"/> Feeling inferior	<input type="checkbox"/> Irrational thoughts	<input type="checkbox"/> Mood swings	<input type="checkbox"/> No problems or concerns

Enter any additional concerns or symptoms:

What stresses or life changes have you experienced recently?

Have you seen a therapist in the past?

Year	Problem	Therapist or clinic	How long

Your family growing up:

<u>Relationship</u>	<u>First Name</u>	<u>Personality / Mental health issues</u>
Mother		
Father		

Childhood:

Click the box beside issues experienced in childhood:

<input type="checkbox"/> Happy childhood	<input type="checkbox"/> Neglected	<input type="checkbox"/> Moved frequently
<input type="checkbox"/> Physically abused	<input type="checkbox"/> Few Friends	<input type="checkbox"/> Sexually abused
<input type="checkbox"/> Weight problems	<input type="checkbox"/> Popular	<input type="checkbox"/> Parents divorced
<input type="checkbox"/> Family fights	<input type="checkbox"/> Poor grades	<input type="checkbox"/> Conflict with teachers
<input type="checkbox"/> Drug or alcohol use	<input type="checkbox"/> Good grades	<input type="checkbox"/> Sexual problems
<input type="checkbox"/> Depressed	<input type="checkbox"/> 'Spoiled'	<input type="checkbox"/> Anxious
<input type="checkbox"/> Not allowed to grow up	<input type="checkbox"/> Attention problems	<input type="checkbox"/> Anger problems

Who lives with you now?

Where are you currently living?

Relationship history:

How many times have you been married?
How old were you at the time of your marriage(s)?
Briefly describe any problems in your current or past marriages or cohabitation relationships:

Education and Occupations:

Are you currently...	<input type="checkbox"/> Working <input type="checkbox"/> In school <input type="checkbox"/> (both) <input type="checkbox"/> (neither)
Highest level of education so far?	
What is (or was) your major or favorite subject?	
How many hours per week are you working?	
In what field do you usually work?	
What is your current or most recent job title?	
How is your satisfaction with	

work/school?

Home Life:

How do you spend personal time? (list hobbies, sports, clubs, groups, family activities, etc.)

How many contacts do you have each month with friends outside of work or school?

Who can you talk with about personal feelings or private matters?

Are you satisfied with your romantic life?

Briefly describe what you like and dislike about your current romantic and friendship lives:

Health:

Check each accident or illness you have experienced:

<input type="checkbox"/> Recent surgery	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Neurological disorder
<input type="checkbox"/> Seizures	<input type="checkbox"/> Infertility	<input type="checkbox"/> Headaches
<input type="checkbox"/> Drug/alcohol abuse treatment	<input type="checkbox"/> Head injury	<input type="checkbox"/> Hormone problems
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Miscarriages

List any other chronic health problems you may have:

How many hours do you sleep in an average night?

How many drinks (containing alcohol) do you consume in an average week?

Which recreational drugs have you used in the last year?

List any prescription or over-the-counter medications you may take, along with the purpose of the medicine:

Do you exercise? How? How often?

Do you use tobacco? How much?

Who is your primary physician? (Include phone number if known.)

When was your last physical?

Are you concerned about your physical health?

Accomplishments / Additional Information:

List your personal strengths and important accomplishments: _____
