Biographical Information Form—Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank. If you are unsure about some information, please give a "best guess" estimate.

Personal History

1) Name: _____ 2) Age: _____ 3) Gender: ___M ___F

4) Address: _____
Street & Number City State Zip

5) Weight: _____ 6) Height: _____ 7) Eye color: _____ 8) Hair color: _____ 9) Race: _____

10) Date of Birth: _____ 11) Years of education: _____

12) Occupation: _____ 13) Home Phone: _____

14) Business Phone: _____ Can we leave a message here? ____ Y ____ N

15) Cell Phone: _____ 16) Email: _____

17) Present Marital Status:

_____ 1) never married
_____ 2) engaged to be married
_____ 3) married now for first time
_____ 4) married now after first time
_____ 5) separated
_____ 6) divorced and not remarried
_____ 7) widowed and not remarried
_____ 8) other (specify) _____

18) If married, are you living with your spouse at present?: Yes____ No____
If married, years married to present spouse: _____

Counseling History

19) Are you receiving counseling services at present?: Yes____ No____
If Yes, please briefly describe: _____

20) Have you received counseling in the past?: Yes_____ No_____
If Yes, please briefly describe: _____

21) What is (are) your main reason(s) for this visit?: _____

22) How long has this problem persisted (from #21)?: _____

23) Under what conditions do your problems usually get worse?: _____

24) Under what conditions are your problems usually improved?: _____

25) How did you hear about this clinic, or who referred you?: _____

Medical History

26) Name and address of your primary physician:
Physician's name: _____
Address: _____

27) List any major illnesses and/or operations you have had: _____
_____

28) List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc.): _____
_____

29) List any other physical concerns you have experienced in the past: _____
_____
_____

30) When was your most recent complete physical exam?: _____
Results of physical exam: _____
_____

31) On average how many hours of sleep do you get daily?: _____

32) Do you have trouble falling asleep at night?: __No __Yes If Yes, describe _____
_____

33) Have you gained/lost over ten pounds in the past year?: __Yes __No, __gained __lost
If Yes, was the gain/loss on purpose?: __Yes __No

34) Describe your appetite (during the past week):
_____ poor appetite _____ average appetite _____ large appetite

35) What medications (and dosages) are you taking at present, and for what purpose?:
Medication Purpose
_____
_____
_____
_____

Religious Concerns

36) What is your present religious affiliation?:
___ 1) Catholic
___ 2) Jewish
___ 3) Protestant (specify denomination if any) _____
___ 4) None, but I believe in God
___ 5) Atheist or agnostic
___ 6) Other (please specify) _____

37) How important is religious commitment to you?:

Unimportant			Average importance			Extremely important
1	2	3	4	5	6	7

38) Do you wish to have your religious beliefs and values incorporated into the counseling process?
__Yes __No __Not sure (If Yes, please explain) _____
_____

Family History

39) Mother's age:_____ If deceased, how old were you when she died?: _____
40) Father's age:_____ If deceased, how old were you when he died?: _____
41) If your parents are separated or divorced, how old were you then?: _____
42) Number of brother(s) _____ Their ages _____ _____ _____ _____ _____ _____
43) Number of sister(s) _____ Their ages _____ _____ _____ _____ _____ _____
44) I was child number _____ in a family of _____ children.
45) Were you adopted or raised with parents other than your natural parents?: Yes___ No ___
46) Briefly describe your relationship with your brothers and/or sisters: _____

_____

_____

_____

47) Which of the following best describes the family in which you grew up?:

WARM AND ACCEPTING				AVERAGE				HOSTILE AND FIGHTING
1	2	3	4	5	6	7	8	9

48) Which of the following best describes the way in which your family raised you?:

ALLOWED ME TO BE VERY INDEPENDENT				AVERAGE				ATTEMPTED TO CONTROL ME
1	2	3	4	5	6	7	8	9

YOUR MOTHER (or mother substitute)

49) Briefly describe your mother: _____

_____

50) How did she discipline you?: _____

_____

51) How did she reward you?: _____

_____

52) How much time did she spend with you when you were a child?: _____

_____ much _____ average _____ little

53) Your mother's occupation when you were a child: _____

_____ stayed home _____ worked outside part-time _____ worked outside full-time

54) How did you get along with your mother when you were a child?:

_____ poorly _____ average _____ well

55) How do you get along with your mother now?:

_____ poorly _____ average _____ well

56) Did your mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development?: Yes _____ No _____
(If Yes, please describe) _____

_____

57) Is there anything unusual about your relationship with your mother?:
Yes _____ No _____ (If Yes, please describe) _____

_____

58) Describe overall how your mother treated the following people as you were growing up:
(Circle one answer for each)

YOUR MOTHER'S TREATMENT OF:	Poor			Average			Excellent
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR FATHER	1	2	3	4	5	6	7

YOUR FATHER (or father substitute)

59) Briefly describe your father: _____

_____

60) How did he discipline you?: _____

_____

61) How did he reward you?: _____

_____

62) How much time did he spend with you when you were a child?:
_____ much _____ average _____ little

63) Your father's occupation when you were a child: _____
_____ stayed home _____ worked outside part-time _____ worked outside full-time

64) How did you get along with your father when you were a child?: _____
_____ poorly _____ average _____ well

65) How do you get along with your father now?:
_____ poorly _____ average _____ well

66) Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development?: Yes_____ No_____
(If Yes, please describe) _____

_____

67) Is there anything unusual about your relationship with your father?: No _____ Yes _____
(If Yes, please describe) _____

_____

68) Describe overall how your father treated the following people as you were growing up:
(Circle one answer for each)

YOUR FATHER'S TREATMENT OF:	Poor			Average			Excellent
1) YOU	1	2	3	4	5	6	7
2) YOUR FAMILY	1	2	3	4	5	6	7
3) YOUR MOTHER	1	2	3	4	5	6	7

Thoughts and Behaviors

69) Please check how often the following thoughts occur to you:

1) Life is hopeless.	____Never	____Rarely	____Sometimes	____Frequently
2) I am lonely.	____Never	____Rarely	____Sometimes	____Frequently
3) No one cares about me.	____Never	____Rarely	____Sometimes	____Frequently
4) I am a failure.	____Never	____Rarely	____Sometimes	____Frequently
5) Most people don't like me.	____Never	____Rarely	____Sometimes	____Frequently
6) I want to die.	____Never	____Rarely	____Sometimes	____Frequently
7) I want to hurt someone.	____Never	____Rarely	____Sometimes	____Frequently
8) I am so stupid.	____Never	____Rarely	____Sometimes	____Frequently
9) I am going crazy.	____Never	____Rarely	____Sometimes	____Frequently
10) I can't concentrate.	____Never	____Rarely	____Sometimes	____Frequently
11) I am so depressed.	____Never	____Rarely	____Sometimes	____Frequently
12) God is disappointed in me.	____Never	____Rarely	____Sometimes	____Frequently
13) I can't be forgiven.	____Never	____Rarely	____Sometimes	____Frequently
14) Why am I so different?	____Never	____Rarely	____Sometimes	____Frequently
15) I can't do anything right.	____Never	____Rarely	____Sometimes	____Frequently
16) People hear my thoughts.	____Never	____Rarely	____Sometimes	____Frequently
17) I have no emotions.	____Never	____Rarely	____Sometimes	____Frequently
18) Someone is watching me.	____Never	____Rarely	____Sometimes	____Frequently
19) I hear voices in my head.	____Never	____Rarely	____Sometimes	____Frequently
20) I am out of control.	____Never	____Rarely	____Sometimes	____Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

Symptoms

70) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

_____ aggression	_____ fatigue	_____ sexual difficulties
_____ alcohol dependence	_____ hallucinations	_____ sick often
_____ anger	_____ heart palpitations	_____ sleeping problems
_____ antisocial behavior	_____ high blood pressure	_____ speech problems
_____ anxiety	_____ hopelessness	_____ suicidal thoughts
_____ avoiding people	_____ impulsivity	_____ thoughts disorganized
_____ chest pain	_____ irritability	_____ trembling
_____ depression	_____ judgment errors	_____ withdrawing
_____ disorientation	_____ loneliness	_____ worrying
_____ distractibility	_____ memory impairment	_____ other (specify)
_____ dizziness	_____ mood shifts	_____
_____ drug dependence	_____ panic attacks	_____
_____ eating disorder	_____ phobias/fears	_____
_____ elevated mood	_____ recurring thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

71) List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

72) List your five greatest weaknesses:

1) _____
2) _____
3) _____
4) _____
5) _____

73) List your main social difficulties: _____

_____

_____

74) List your main love and sex difficulties: _____

_____

_____

75) List your main difficulties at school or work: _____

_____

_____

76) List your main difficulties at home: _____

_____

_____

77) List your behaviors that you would like to change: _____

_____

_____

_____

78) Additional information you believe would be helpful: _____

_____

_____

_____

_____

_____

_____