

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.

Personal History

1) Name: _____ 2) Age: _____ 3) Gender: ___M___F

4) Address: _____
Street & Number City State Zip

5) Home Phone _____ 6) Cell phone _____

7) email _____

10) Today's Date: _____ 11) Date of Birth: _____ 12) Years of education: _____

13) Occupation: _____ 14) Home Phone: _____ 15) Business Phone: _____

16) Present Marital Status:

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

17) If married, are you living with your spouse at present?: Yes _____ No _____

18) 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?: _____

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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?:
- | <u>Medication</u> | <u>Purpose</u> |
|-------------------|----------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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 desire to have your religious beliefs and values incorporated into the counseling process?:
 Yes No Not sure (If Yes, please explain) _____

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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

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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 |

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Symptoms

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

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

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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: _____

PLEASE BRING THIS AND OTHER MATERIALS TO YOUR INTAKE APPOINTMENT.