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A CLINICAL PSYCHOLOGY CORPORATION

BIOGRAPHICAL INFORMATION

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. If certain questions do not apply to you, please leave them blank. Thank you.

Name ____ Today's Date ____________________

Present Marital Status:

___ never married ___ separated

___ engaged ___ divorced, not remarried

___ first marriage ___ widowed, not remarried

___ remarried ___ other (please specify)

____

If married, how long? (years/months) __________

Are you presently living with your spouse? Yes No

Age ________ Sex: M F

Employed? Yes No

Occupation/Position ______________

Student? Full Part No

School _________________________

Highest Level of Education ________

Number of Children ______________

Referred By ____

Are you currently receiving other counseling? Yes No

If yes, please describe (reason for treatment, length of treatment, name of therapist) ____________

Have you received counseling in the past? Yes No

If yes, please describe (reason for treatment, length of treatment, name of therapist) ____________

Reason for ending treatment ____

What is your main reason for coming to counseling? ____

How long has this problem/situation persisted? ____

Please continue to the next page

Is this related to: (please circle) Employment Auto Accident Other Accident Not Related

Under what conditions does your problem/situation get worse?

____

____

Under what conditions does your problem/situation improve?

____

____

Are you currently under care for any medical problems/conditions? Yes No

If yes, please describe ____

Name of physician giving care ____

address ___________________________________ phone _____________________

Do you have other ongoing or past medical conditions/problems? Yes No

If yes, please describe

____

____

Please describe any previous medical hospitalizations (describe reasons and hospitalization dates)

____

____

Please list any current medications (names, amounts taken, and for what purpose)

____

____

Name of personal physician ____

Address ____ phone _____________________

Date of last visit ______________________

Please continue to the next page

Please describe any surgery you have had (date and procedure)

____

Please describe any physical handicap(s) you have ____

Please describe your alcohol intake (type, amount, frequency) _______________________________

Please describe your caffeine intake (type, amount, frequency) ______________________________

Please describe your tobacco intake (type, amount, frequency) ______________________________

Any past or current alcohol or drug treatment? Yes No

If yes, please describe (dates, treatment facility, type of treatment)

____

How many hours of sleep do you get per night? __________

Do you have problems falling asleep at night? Yes No

Are you tired during the day? Yes No

Describe your appetite: poor average large

Does your weight fluctuate? Yes No

If yes, by how much? ______________________________________

Do you get physical exercise? Yes No

If yes, what type and how often? ____

FOR FEMALES:

Is your menstrual cycle regular? Yes No Post

If no, please explain ____

Do you have pain with your cycle? Yes No

If yes, please explain ____

Do your periods affect your mood? Yes No

If yes, please explain ____

Do your periods affect your energy level? Yes No

If yes, please explain ____

Please continue to the next page

RELIGIOUS CONCERNS

What is your present religious affiliation?

___ Protestant (denomination, if any) _________________________________

___ Catholic

___ Jewish

___ Muslim

___ Atheist or Agnostic

___ None, but I believe in God

___ Other (specify) ____

How important is your religious commitment to you?

(please circle) unimportant average very important

Would you like to have your religious beliefs and values incorporated into counseling?

Yes No Not Sure

If yes, please explain ____

FAMILY HISTORY

Check any of the following that applied to you during childhood/adolescence:

___ happy childhood	___ excelled at school	___ learning disabilities
___ unhappy childhood	___ not enough friends	___ severely punished
___ emotional/behavioral problems	___ school problems	___ sexually abused
___ legal trouble	___ financial problems	___ severely bullied or teased
___ death in family	___ strong religious convictions	___ eating disorder
___ medical problems	___ drug use	___ other (specify)
___ ignored	___ alcohol use	__________________________

Please continue to the next page

What were your scholastic strengths? ____

What were your scholastic weaknesses? ____

Were you raised by your natural parents? Yes No

If you were raised by anyone other than your natural parents, who raised you and between what years?

____

Current status of your parents' marriage: married separated divorced one/both deceased

Total number of children in your family ________________________

Your birth order in the family ________________________________

Current age(s) of brother(s) ___________________ Current age(s) of sister(s) ________________

Any significant details about your siblings? ____

Please describe your relationship(s) with your sibling(s)

____

Please describe any significant deaths in your family

____

Using the following scale (1-9), which best describes the family in which you grew up?

WARM, ACCEPTING 1 2 3 4 5 6 7 8 9 HARSH, HOSTILE, UNACCEPTING

Using the following scale (1-9), which best describes the way in which your family raised you?

ALLOWED INDEPENDENCE 1 2 3 4 5 6 7 8 9 ATTEMPTED TO CONTROL

Were you able to confide in your parents? Yes No Explain:

____

Did you feel loved and respected by your parents? Yes No Explain:

____

Please continue to the next page

YOUR MOTHER (OR MOTHER SUBSTITUTE)

___ natural mother ___ adopted mother ___ stepmother ___ foster mother ___ other

her age ________ her occupation ____

her health ________________________ If deceased, how old were you at the time? _______________

Give a description of your mother's (or mother substitute) personality and her attitude toward you (past and present).

____

____

____

____

Did your mother have any problems (i.e. drugs, alcoholism, violence, depression, etc.) that may have affected your childhood? (please circle) Yes No

If yes, please describe.

____

YOUR FATHER (OR FATHER SUBSTITUTE)

___ natural father ___ adopted father ___ stepfather ___ foster father ___ other

his age _________ his occupation ____

his health ______________________ If deceased, how old were you at the time? ______________

Give a description of your father's (or father substitute) personality and his attitude toward you (past and present)

____

____

____

____

Did your father have any problems (i.e. drugs, alcoholism, violence, depression, etc.) that may have affected your childhood? (please circle) Yes No

If yes, please describe.

____

Please continue to the next page

BEHAVIORS AND SYMPTOMS

Check each of the following items that often apply to you:

___ overeating	___ aggression/anger	___ hallucinations	___ crying
___ drug use/abuse	___ suicidal thoughts	___ dizziness	___ sexual difficulties
___ alcohol abuse	___ depression	___ heart palpitations	___ antisocial behavior
___ ↑blood pressure	___ anxiety	___ phobias/fears	___ judgment errors
___ sleeping problems	___ withdrawl	___ panic attacks	___ recurring thoughts
___ appetite problems	___ irritability	___ mood shifts	___ thoughts disorganized
___ memory impairment	___ concentration difficulties	___ disorientation	___ fatigue
___ speech problems	___ loneliness	___ trembling	___ other (specify)
___ chest pains	___ elevated mood	___ worry	____________________
___ hear voices	___ dissociation	___ nightmares	____________________

Please describe how each of the items you checked impairs your functioning (i.e. socially, emotionally, physically, etc.)

____

____

____

____

PHYSICAL SENSATIONS

Check each of the following physical sensations that often apply to you:

___ abdominal pain	___ tingling	___ watery eyes	___ blackouts
___ pain with urination	___ numbness	___ flushes	___ excessive sweating
___ menstrual difficulties	___ bowel disturbances	___ hear things	___ visual disturbances
___ headaches	___ stomach problems	___ nausea	___ hearing problems
___ muscle spasms	___ twitches	___ skin problems	___ other (specify)
___ tension	___ back pain	___ dry mouth	____________________

Please continue to the next page

___ sexual disturbances ___ tremors ___ burning/itching skin ___________________

___ unable to relax ___ fainting spells ___ don't like to be touched _______________

Which of the items that you checked are the most unpleasant? Please explain.

____

____

____

THOUGHTS AND BELIEFS

Check each of the following that you may use to describe yourself:

___ intelligent ___ evil ___ confused ___ memory problems

___ confident ___ crazy ___ ugly ___ can't make decisions

___ worthwhile ___ considerate ___ stupid ___ suicidal ideas

___ ambitious ___ morally degenerate ___ naïve` ___ perservering

___ sensitive ___ deviant ___ inadequate ___ undersirable

___ loyal ___ unattractive ___ incompetent ___ lazy

___ full of regrets ___ unloveable ___ horrible thoughts ___ dishonest

___ trustworthy ___ honest ___ conflicted ___ other (specify)

___ worthless ___ hard working ___ good sense of humor ___________________

Please comment about each of the above thoughts you checked which occur frequently (give examples, their frequency, duration, effects on you, etc.)

____

____

____

Please continue to the next page

Is there any additional information that you think your therapist should be aware of?

____
____
____
____
____
____
____
____
____
____
____

Thank you for your cooperation.

Please continue to the next page