

Biographical Information Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. You may leave any questions blank that you feel do not apply to you or that you prefer not to answer. All information is confidential as outlined in the Office Policy Form and the HIPAA Notice of Privacy Practices.

Personal History

Name: _____
Address: _____
Date of Birth: _____ Age: _____ Place of Birth: _____
Gender: _____ Ethnicity/Racial Identity: _____
Level of Education/Degree: _____ Occupation: _____

Contact Information:

Home: _____ Is it OK to leave a confidential message? Yes No
Cell: _____ Is it OK to leave a confidential message? Yes No
Work: _____ Is it OK to leave a confidential message? Yes No
Fax: _____

Emergency Contact Information (Name/Relationship/Phone):

Counseling Goals & History

What are your main reasons for coming to counseling?

Have you received counseling in the past? Yes No

If yes, please describe:

Social History

Marital/ Relationship Status (Check all that apply):

- Single Dating Partnered Married Separated Divorced Widowed

Please complete the following regarding your family (as applicable):

Name	Do they live in household?	Age	Occupation	Quality of Relationship
Spouse:				
Children:				
Parents:				
Siblings:				

Please list any family history of mental health issues and/or drug and alcohol issues: _____

Tracy Chapman, PsyD

**Licensed Psychologist
PSY18406**

Medical History

Medical Provider (Name/Phone): _____

Do you exercise regularly? Please describe: _____

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

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

Approximate date of most recent physical exam: _____

Please list any medications, vitamins and/or supplements you are currently taking:

Are you having any difficulties with your sleeping patterns? Yes No
If yes, please describe: _____

Please complete the following substance assessment:

Substance	Current Use (last 6 months)			Past Use		
	Yes	No	Amount/ Frequency	Yes	No	Amount/ Frequency
Caffeine						
Alcohol						
Cigarettes						
Tobacco						
Marijuana						
Other:						

Current Symptoms

Are you currently experiencing thoughts of hurting yourself? Yes No
Are you currently experiencing thoughts of hurting someone else? Yes No

Please check any symptoms that might be bothering you:

- | | | |
|--|---|---|
| <input type="checkbox"/> aggression | <input type="checkbox"/> failure | <input type="checkbox"/> loneliness |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> fatigue | <input type="checkbox"/> low motivation |
| <input type="checkbox"/> anger | <input type="checkbox"/> fears | <input type="checkbox"/> memory problems |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> grief | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> avoiding people | <input type="checkbox"/> guilt | <input type="checkbox"/> panic attacks |
| <input type="checkbox"/> attention | <input type="checkbox"/> headaches | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> confusion | <input type="checkbox"/> health problems | <input type="checkbox"/> poor self-esteem |
| <input type="checkbox"/> depressed mood | <input type="checkbox"/> hopelessness | <input type="checkbox"/> procrastination |
| <input type="checkbox"/> difficulties making decisions | <input type="checkbox"/> impulsiveness | <input type="checkbox"/> self-harming behaviors |
| <input type="checkbox"/> distractibility | <input type="checkbox"/> inferiority feelings | <input type="checkbox"/> sexual problems |
| <input type="checkbox"/> emptiness | <input type="checkbox"/> irritability | <input type="checkbox"/> weight problems |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> judgment problems | |

Please check any current stressors you are experiencing:

- | | |
|--|--|
| <input type="checkbox"/> abuse | <input type="checkbox"/> legal problems |
| <input type="checkbox"/> childhood problems | <input type="checkbox"/> poor social support |
| <input type="checkbox"/> custody problems | <input type="checkbox"/> parenting problems |
| <input type="checkbox"/> divorce/separation | <input type="checkbox"/> relationship problems |
| <input type="checkbox"/> financial problems | <input type="checkbox"/> school problems |
| <input type="checkbox"/> gambling | <input type="checkbox"/> work problems |
| <input type="checkbox"/> interpersonal conflicts | |

Is there any additional information that you would like to share that would be helpful for our work together? _____

