Biographical Background Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. *All information is confidential as outlined in the informed consent form*.

Name _____

Date _____

Address _____

City _____ Zip _____

Date of Birth _____ Gender Identity _____

Telephone: H: _____W: _____Cell:_____

May I leave a message? If so, on which number? _____

E-mail:_____ May I e-mail you? [] Yes or [] No

(*Please note: Email correspondence is not considered to be a confidential medium of communication.)*

Occupation :_____

Employer/School: _____

Emergency Contact: _____ Phone:_____

Medical Doctor (Name/Phone): _____

Referral Source: _____

Current Marital Status: _____

Children (Names/Ages) _____

Reason for Visit: _____
_____
_____

Have you previously received any type of mental health services? [] Yes [] No

Have you ever been prescribed psychiatric medication? [] Yes [] No

Are currently taking any prescription medication? [] Yes [] No

How often do you drink alcohol? [] Frequently [] Infrequently [] Never
If Frequently: # of Drinks/Wk ____

How often do you engage in recreational drug use? [] Frequently [] Infrequently [] Never

Please check if the following symptoms are affecting you:

- ☐ Depression Panic Attacks
- ☐ Feel Hopeless
- ☐ Rapid heartbeat/palpitations
- ☐ Think about suicide
- ☐ Constant worry
- ☐ Feel irritable
- ☐ Fear of social gatherings
- ☐ Cry easily
- ☐ Feel anxious, on edge
- ☐ Loneliness
- ☐ Unwanted or distressing thoughts
- ☐ Feel guilty
- ☐ Repetitive behaviors
- ☐ Feel worthless
- ☐ Nightmares
- ☐ Withdrawal from people
- ☐ Phobias, unreasonable fears
- ☐ Unable to have a good time
- ☐ Thoughts about traumatic events
- ☐ Lost interest in usual activities
- ☐ Bowel disturbances
- ☐ Unmotivated to complete daily tasks
- ☐ Headaches
- ☐ Suicidal feelings
- ☐ Decreased energy/fatigue
- ☐ Chronic Pain
- ☐ Gender identity conflict
- ☐ Sexual identity confusion
- ☐ Other medical problems
- ☐ Lost interest in sex
- ☐ Decreased attention span
- ☐ Sexual performance problems
- ☐ Inattentive/distractible
- ☐ Trouble falling asleep
- ☐ Memory problems
- ☐ Trouble waking up
- ☐ Spending sprees
- ☐ Trouble staying asleep
- ☐ Racing thoughts
- ☐ Recent weight gain or loss
- ☐ Hear voices
- ☐ No appetite
- ☐ See things that are not there
- ☐ Anger outbursts
- ☐ Binge eating
- ☐ Think about hurting someone
- ☐ Intentional vomiting

Please check if you have a family history of any of the following:

- ☐ Alcohol Abuse
- ☐ Substance Abuse
- ☐ Depression
- ☐ Suicide Attempts
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Eating Disorders

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