Biographical Information

Name_____Date Form Completed_____

Gender and pronoun preferences_____

Sexual orientation:_____

Ethnic/racial Identification:_____

Emergency contact (Name)_____

Relationship to you_____ Telephone_____

What are your reasons for seeking therapy now?_____

_____

_____

_____

What would you like to accomplish out of your time in therapy?_____

_____

_____

_____

Prior therapy experiences:

Year	Reason	Therapist Name	Duration

_____

_____

_____

_____

Checklist of Concerns

___Abuse survivor issues

___Abandonment and/or fear of

___Adult child of an alcoholic/addict

___Anger management

___Anxiety/worry

___Communication Problems

___Creative blocks/performance issues

___Crying spells

___Depression

___Difficulty making decisions

___Divorce /separation/break-ups

___Eating/food/weight issues

___Emotional/verbal abuse

___Financial problems/money misuse

___Friendships

___Grief & Loss

___Hallucinations (visual/auditory/tactile)

___Hopelessness

___Interpersonal conflicts

___Impulsive behavior/poor self-control

___Infidelity/affair recovery

___Lack of life purpose/meaning

___Legal difficulties

___Loneliness/social withdrawal

___Marital/relationship problems

___Memory/concentration

___Mood swings

___Recurring/unusual thoughts

___Panic

___Parenting/caregiving issues

___Perfectionism

___Phobias/specific fears

___Physical illness/pain

___Physical/sexual abuse

___Seasonality of moods

___Self-esteem/feeling inferior

___Self-harm

___Sexual concerns

___Sleep difficulties

___Social anxiety

___Stress

___Substance use (yours or others)

___Suicidal thoughts/plans/attempts

___Trust issues

___Unusually sensitive/irritable

___Violent thoughts/behaviors

___Work problems/career directions

Enter any additional problems or concerns in the blank space below:

What stresses or life changes have you experienced recently?

Current Relationships/Household

Current relationship status: Single___Married/Partnered___Separated/Divorced___ Widowed___Other___

If applicable: (partner's name, living situation, length/emotional tone of relationship)

_____

_____

_____

Children (name, age, gender, emotional tone of relationship)_____

_____

_____

Household composition (please list names, ages, and relation-to-you of all people you live with)_____

_____

_____

_____

Please list any prior significant relationships/marriages including partner's name and length of relationship:_____

_____

_____

Your Family Growing Up

Please list names, ages, and the tone of your relationship with them then and now

Father_____

_____

Mother_____

_____

Siblings_____

_____

_____

If you need more space for additional family members please continue below:

Please briefly list any special or traumatic circumstances, changes or losses that occurred in either childhood or adulthood:

Employment/Education

Current employer/occupation_____

_____

Education: Highest level of education completed?_____

Colleges attended and areas of study _____

_____

_____

Health Information

Previous mental health/substance-use hospitalizations or outpatient treatment programs attended:

Date Location Reason for admission

_____

_____

_____

Please list any prescription or over-the-counter medications and vitamins/herbal supplements you take, along with the purpose and dosage of the medication:

_____

_____

_____

_____

Primary Physician's name_____Telephone_____

Psychiatrist's name_____ Telephone_____

List any health problems you may have:_____

_____

_____

How many hours do you sleep in an average night?_____

How many drinks (containing alcohol) do you consume in an average week?_____

_____

What recreational drugs have you used in the last year?_____

_____

Do you exercise? How? How often? _____

_____

_____

Do you use tobacco? How much?_____

What do you consider to be some of your personal strengths?_____

_____

_____

List any additional information which may be useful to share with your therapist: