Biographical Information

Your therapist asks that you complete this form, which will provide information useful in treatment. It will probably take about 30 minutes to complete this form. Please complete it before your next appointment. If you are not the primary client, please complete this form to the best of your knowledge about the primary client.

Have you seen a therapist in the past?

☐ no prior mental health treatment

Year	Problem	Therapist/Clinic	How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What stresses or life changes have you experienced recently?

_____

_____

_____

_____

_____

Symptoms

Check the box beside each concern experienced recently.

- ☐ Anxiety
- ☐ Panic
- ☐ Crying spells
- ☐ Treated unfairly
- ☐ Restlessness
- ☐ Drug use
- ☐ Stress
- ☐ Guilt feelings
- ☐ Compulsions
- ☐ Specific fears
- ☐ Feeling abandoned
- ☐ Irritability
- ☐ Religious concerns
- ☐ Feeling inferior
- ☐ Depression
- ☐ Unusual thoughts
- ☐ Memory problems
- ☐ Frequent pain
- ☐ Nausea
- ☐ Drinking problem
- ☐ Shyness
- ☐ Suspicion
- ☐ Worry
- ☐ Mourning
- ☐ Meaninglessness
- ☐ Social withdrawal
- ☐ Disappointment
- ☐ Irrational thoughts
- ☐ Sleep problems
- ☐ Anger outbursts
- ☐ Sexual problems
- ☐ Low energy
- ☐ Eating disorder
- ☐ Boredom
- ☐ Work problems
- ☐ Loneliness
- ☐ Money problems
- ☐ Physical illness
- ☐ Perfectionism
- ☐ Feeling misunderstood
- ☐ Impulsive
- ☐ Mood swings
- ☐ Thoughts of suicide
- ☐ Changes in weight
- ☐ Relationship difficulties
- ☐ Concentration problems
- ☐ Legal difficulties
- ☐ Hopelessness
- ☐ Confusion
- ☐ Thoughts of hurting others
- ☐ Difficulty with decisions
- ☐ Poor motivation
- ☐ Unusually sensitive
- ☐ Troublesome thoughts
- ☐ Hearing strange voices
- ☐ No problems or concerns

Enter any other concerns or symptoms below.

_____
_____
_____
_____

What stresses or life changes have you experienced recently?

_____
_____
_____
_____

Your family growing up

Relationship	First Name	Personality/Mental Health Issues
Mother		
Father		

If you need more space, continue below:

_____
_____
_____
_____

Childhood:

Check the box beside issues experienced in childhood

☐ Happy Childhood
☐ Physically abused
☐ Weight problems
☐ Family fights
☐ Drug or alcohol use
☐ Depressed
☐ Not allowed to grow up
☐ Neglected
☐ Few friends
☐ Popular
☐ Poor grades
☐ Good grades
☐ 'Spoiled'
☐ Attention problems
☐ Moved frequently
☐ Sexually abused
☐ Parents' divorced
☐ Conflict with teachers
☐ Sexual problems
☐ Anxious
☐ Anger problems

Enter any additional childhood experiences or symptoms below:

_____
_____
_____
_____

Who lives with you now?

Relationship	First Name	Personality/Mental Health Issues

If you need more space, continue below:

_____
_____
_____
_____

Where are you currently living?

- ☐ House
- ☐ Apartment
- ☐ With relatives
- ☐ Retirement community
- ☐ Health care facility
- ☐ Dorm or campus apartment
- ☐ Other living arrangement

Relationship history

How many times have you been married?_____

How old were you at the time of your marriage(s)? _____
_____

Briefly describe any problems in your current or past marriages or cohabitation relationships:

_____
_____

Education and Occupations

Are you currently… ☐Working ☐In school ☐both ☐neither

Highest level of education so far? _____

What is (or was) your major or favorite subject? _____

How many hours per week are you working? _____

In what field do you usually work? _____

What is your current job title? _____

Briefly describe what you like and dislike about your employment or school:

_____
_____
_____
_____

Home Life

How do you spend personal time? (List hobbies, sports, clubs, group, family activities, etc.)

_____
_____
_____
_____
_____
_____

How many contacts do you have each month with friends outside of work or school?

_____
_____

Are you satisfied with your romantic life? __yes __no __

Briefly describe what you like and dislike about your current romantic and friendship lives:

_____
_____
_____
_____

Health

Check each accident or illness you have experienced:

- ☐ Recent surgery
- ☐ Seizures
- ☐ Drug/alcohol abuse treatment
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Infertility
- ☐ Head Injury
- ☐ Thyroid problem
- ☐ Neurological disorder
- ☐ Headaches
- ☐ Hormone problems
- ☐ Miscarriages

List any other chronic 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? _____

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

_____

List any prescription or over-the-counter medications you may take, along with the purpose of the medicine:

Name of medicine	**Purpose of medicine**
_____	_____
_____	_____
_____	_____
_____	_____

Do you exercise? How? How often?

_____

_____

_____

Do you use tobacco? How much?

_____

Who is your primary physician? (Include phone number if known)

_____

When was your last physical? _____

Are you concerned about your health? _____

Accomplishments/Additional Information

List your personal strengths and important accomplishments:

_____
_____
_____
_____

List any additional information that might be important for your therapist to know:

_____
_____
_____
_____

What is your name? (Who filled out this form?) _____