BIOGRAPHICAL INFORMATION

Patient Name: _____ **Date Form Completed:** _____

Parent / Legal Guardian Name: _____

Symptoms

Check the box beside each concern experienced recently

☐ Anxiety	☐ Depression	☐ Sleeping Problems	☐ Thoughts of Suicide
☐ Panic	☐ Unusual thoughts	☐ Anger Outbursts	☐ Weight Change
☐ Crying Spells	☐ Memory Problems	☐ Sexual Problems	☐ Relationship Issues
☐ Treated Unfairly	☐ Frequent Pain	☐ Low Energy/Lethargic	☐ Concentration problems
☐ Restlessness	☐ Nausea	☐ Eating Disorder	☐ Legal Difficulties
☐ Drug Use	☐ Alcohol Abuse/Heavy Use	☐ Boredom	☐ Hopelessness
☐ Stress	☐ Shyness	☐ Work Problems	☐ Confusion
☐ Feelings of Guilt	☐ Suspicion	☐ Loneliness	☐ Violent Thoughts
☐ Compulsions	☐ Worry	☐ Financial Problems	☐ Difficulty with decisions
☐ Specific Fears	☐ Mourning	☐ Physical Illness	☐ Lack of Motivation
☐ Feeling Abandoned	☐ Meaninglessness	☐ Perfectionism	☐ Unusually Sensitive
☐ Irritability	☐ Social Withdrawal	☐ Feeling Misunderstood	☐ Troublesome Thoughts
☐ Religious Concerns	☐ Disappointment	☐ Impulsive Behavior	☐ Hearing strange voices
☐ Feelings of Inferiority	☐ Irrational Thoughts	☐ Mood Swings	☐ No Present Concerns

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

What stresses or life changes have you experienced recently?

Have you seen a therapist in the past?

Year	Problem	Therapist or Clinic	Treatment Duration

Your family growing up:

Relationship	First Name	Personality / Mental health issues
Mother		
Father		

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

Childhood

Check the box beside issues experienced in childhood

☐ Happy Childhood	☐ Neglected	☐ Moved Frequently
☐ Physically Abused	☐ Few Friends	☐ Sexually Abused
☐ Weight Problems	☐ Popular	☐ Parents Divorced
☐ Family Fights	☐ Poor Grades	☐ Conflict with Teachers
☐ Drug/Alcohol Use	☐ Good Grades	☐ Sexual Problems
☐ Depressed	☐ "Spoiled"	☐ Anxious
☐ Not Allowed to Grow-Up	☐ Attention Problems	☐ Anger Problems

Enter any additional childhood experiences or symptoms in the space below:

Where are you currently living?

Check the applicable box

☐ Dorm/Campus Apartment	☐ Health Care Facility
☐ Apartment	☐ Retirement Community
☐ House	☐ With Relatives
☐ Other	

Who lives with you now?

Relationship	First Name	Personality / Mental health issues

Enter any additional occupants in the space below:

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 Occupation

Are you currently? (circle one) **Working** **In School** **(both)** **(neither)**

Highest level of education completed? _____

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 or most recent job title? _____

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

_____

_____

Home Life

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

_____

_____

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

Who can you talk with about personal feelings or private matters? _____

Are you satisfied with your romantic life? _____

Briefly describe what you like and dislike about your current romantic relationships and friendships:

Health

Check each accident or illness you have experienced:

- ☐ Recent surgery
- ☐ Seizures
- ☐ Drug/alcohol abuse treatment
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Infertility
- ☐ Head injury
- ☐ Thyroid problems
- ☐ 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: _____

_____

_____

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 physical health? _____

Accomplishments & Additional Information

List your personal strengths and important accomplishments:

List any additional information which may be of use to your mental health professional: