BIOGRAPHICAL INFORMATION-INTAKE FORM

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Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ **MALE/FEMALE:** _____ **DATE :**_____

DATE OF BIRTH/PLACE: _____ **AGE:** _____

ADDRESS: _____

TELEPHONE: H: _____ **Cell:** _____ **FAX:** _____

FOR ROUTINE MESSAGES: E-mail: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____**E-mail:** _____

HIGHEST GRADE/DEGREE: _____ **TYPE OF DEGREE:** _____

PERSON & PHONE NO. TO CALL IN EMERGENCY: _____

CURRENT INSURANCE TYPE:_____
I.D. or SUBSCRIBER NUMBER:_____
INSURANCE PHONE NUMBER:_____
HOW DO YOU PLAN ON PAYING FOR SERVICES?:_____

Referral Source/ How did you hear about Dr. Protzel?:_____

OCCUPATION (former. if retired): _____

PRESENTING PROBLEM/Reason for visit: (be as specific as you can: when did it start, how does it affect you…):

_____

_____

_____

Estimate the severity of above problem: Mild-Moderate-Severe-Very severe

DESCRIBE HOW YOU ARE FEELING CURRENTLY & IN THE PAST 2 WEEKS. Why is this the case?:

_____

_____

CURRENT: Marital status:_____Live with someone:_____ Name: _____Years: _____

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile)**:**

_____

_____

_____

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. _____
2. _____
3. _____
4. _____
5. _____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

Mother:_____

_____

Step-parents_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1. _____
2. _____
3. _____
4. _____

MEDICAL DOCTOR/S (name /phone): _____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

_____

SPECIFY <u>MEDICATIONS</u> you are presently taking and for what. <u>PRINT</u> clearly:

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (using which drugs/alcohol?, addicted?, AA, NA, treatments)**:**

_____

_____

_____

HISTORY OF SUICIDE ATTEMPT/S, SELF HARM, or **VIOLENT BEHAVIOR:**

*Have you ever tried to commit suicide, harm yourself, or seriously harm another person? Yes / No

If yes, please explain _____

_____

*Are you currently suicidal? Yes / No If yes, do you have a plan? Yes / No / N/A

*Are you currently homicidal or thinking about seriously harming a specific person? Yes / No

*Are you currently hearing voices other than your own internal voice and/or other smell, visual, or taste hallucinations? Yes / No

*Are you currently engaging in any self harm (cutting, burning, etc.) activities? Yes / No

*Are you in any particular danger currently? Yes / No If yes, please explain_____

*Have you experienced a traumatic event recently? Yes / No If yes, please explain_____

_____

*Have you ever been arrested? Yes / No If yes, please explain_____

_____

FAMILY MEDICAL HISTORY (Describe any <u>illness</u> that runs in the family: cancer, epilepsy, etc)**:**

_____

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. _____

_____

_____

2. _____

_____

_____

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

_____

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time

_____

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

_____

_____

What gives you the most joy or pleasure in your life?

_____

_____

What are your main worries or fears?

_____

_____

What are your goals for therapy? What change would you like to see?

_____

_____

Please add below any other information you would like me to know about you and your situation.

_____

_____

_____

_____

_____

_____

Please indicate that the above information is accurate and true by signing and dating below:

_____

Client name **Date**

_____

Legal Guardian (if applicable) **Date**

*Reviewed by therapist (therapist/date):*_____