



Biographical Information Form: Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible.

Today's Date: _____

PERSONAL HISTORY

- 1) Name: _____ 2) Age: ____ 3) Gender: M ____ F ____
4) Race: _____ 5) Years of Education: _____
6) Occupation: _____
7) Present Marital Status: _____
8) If married, years married to present spouse: _____

COUNSELING HISTORY

- 9) Have you received counseling in the past? Yes ____ No ____
If Yes, please briefly describe: _____

- 10) Are you currently seeing a psychiatrist? Yes ____ No ____
If Yes, name of psychiatrist: _____

- 11) Have you ever been hospitalized for a psychiatric condition? Yes ____ No ____
If Yes, describe: _____

- 12) What is (are) your main reason(s) for this visit? _____

13) How long has this problem persisted (from #12)? _____

14) Under what conditions do your problems usually get worse? _____

15) Under what conditions are your problems usually improved? _____

16) How did you hear about this clinic, or who referred you? _____

17) Name and address of your primary physician:

Physician's Name: _____

Address/Phone: _____

18) List any major illnesses and/or operations you have had: _____

19) List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.): _____

20) When was your most recent complete physical exam? _____
Results of physical exam: _____

21) On average how many hours of sleep do you get daily? _____

22) Do you have trouble falling asleep at night? Yes ___ No ___

If Yes, describe: _____

23) Have you gained/lost over ten pounds in the past year? Yes ___ No ___

Gained ___ Lost ___

If Yes, was the gain/loss on purpose? Yes ___ No ___

24) Describe your appetite (during the past week):

Poor appetite ___ Average appetite ___ Large appetite ___

25) What medications (and dosages) are you taking at present, and for what purpose?

Medication

Purpose

26) Please list past medication trials and dosage: _____

27) What is your present religious affiliation?

Catholic ____

Jewish ____

Protestant ____ (specify denomination if any): _____

None, but I believe in God ____

Atheist or Agnostic ____

Other ____ (please specify): _____

28) How important is religious commitment to you?

Unimportant		Average Importance					Extremely Important
1	2	3	4	5	6	7	

29) Mother's age: _____ Father's Age: _____

30) If your parents separated or divorced, how old were you then? _____

31) Number of brother(s) _____ Their ages: _____

32) Number of sister(s) _____ Their ages: _____

33) I was child number ____ in a family of ____ children.

34) Were you adopted or raised with parents other than your natural parents?

Yes ____ No ____

35) Briefly describe your relationship with your brothers and/or sisters:

36) Which of the following best describes the family in which you grew up?

Warm and accepting			Average			Hostile and fighting		
1	2	3	4	5	6	7	8	9

37) Which of the following best describes the way in which your family raised you?

Allowed me to be very independent			Average			Attempted to control me		
1	2	3	4	5	6	7	8	9

Your Mother (or mother substitute)

38) Briefly describe your mother:

39) How did she discipline you?

40) How did she reward you?

41) How much time did she spend with you when you were a child?

Much ___ Average ___ Little ___

42) Your mother's occupation when you were a child:

Stayed home ___ Worked outside part-time ___ Worked outside full-time ___

43) How did you get along with your mother when you were a child?

Poorly ___ Average ___ Well ___

44) How do you get along with your mother now?

Poorly ___ Average ___ Well ___

45) Did your mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development? Yes ___ No ___

If yes, please describe: _____

46) Is there anything unusual about your relationship with your mother? Yes ___ No ___

If yes, please describe: _____

47) Describe overall how your mother treated the following people as you were growing up (Circle one answer for each) :

Your Mother's Treatment of:	Poor		Average			Excellent	
1) You	1	2	3	4	5	6	7
2) Your Family	1	2	3	4	5	6	7
3) Your Father	1	2	3	4	5	6	7

Your Father (or father substitute)

48) Briefly describe your father:

49) How did he discipline you?

50) How did he reward you?

51) How much time did he spend with you when you were a child?

Much ___ Average ___ Little ___

52) Your father's occupation when you were a child:

Stayed home ___ Worked outside part-time ___ Worked outside full-time ___

53) How did you get along with your father when you were a child?

Poorly ___ Average ___ Well ___

54) How do you get along with your father now?

Poorly ___ Average ___ Well ___

55) Did your father have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development? Yes ___ No ___

If yes, please describe: _____

56) Is there anything unusual about your relationship with your father? Yes ___ No ___

If yes, please describe: _____

57) Describe overall how your father treated the following people as you were growing up (Circle one answer for each) :

Your Father's Treatment of:	Poor			Average			Excellent
1) You	1	2	3	4	5	6	7
2) Your Family	1	2	3	4	5	6	7
3) Your Mother	1	2	3	4	5	6	7

THOUGHTS AND BEHAVIORS

58) Please check how often the following thoughts occur to you:

- | | | | | |
|----------------------------|-----------|------------|---------------|-----------|
| 1) Life is hopeless. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 2) I am lonely. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 3) No one cares. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 4) I am a failure. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 5) People don't like. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 6) I want to die. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 7) I want to hurt someone. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 8) I am so stupid. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 9) I am going crazy. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |
| 10) I can't concentrate. | Never ___ | Rarely ___ | Sometimes ___ | Often ___ |

- 11) I am so depressed. Never ___ Rarely ___ Sometimes ___ Often ___
12) I can't be forgiven. Never ___ Rarely ___ Sometimes ___ Often ___
13) Why am I so different? Never ___ Rarely ___ Sometimes ___ Often ___
14) People hear my thoughts. Never ___ Rarely ___ Sometimes ___ Often ___
15) I have no emotions. Never ___ Rarely ___ Sometimes ___ Often ___
16) Someone is watching me. Never ___ Rarely ___ Sometimes ___ Often ___
17) I hear voices in my head. Never ___ Rarely ___ Sometimes ___ Often ___
18) I am out of control. Never ___ Rarely ___ Sometimes ___ Often ___

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thought that occur frequently or are a concern to you. Use the back of this sheet if necessary.

SYMPTOMS

59) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--------------------------|--------------------------|----------------------------|
| Aggression ____ | Fatigue ____ | Sexual difficulties ____ |
| Alcohol dependence ____ | Hallucinations ____ | Sick often ____ |
| Anger ____ | Heart palpitations ____ | Sleeping problems ____ |
| Antisocial behavior ____ | High blood pressure ____ | Speech problems ____ |
| Anxiety ____ | Hopelessness ____ | Suicidal thoughts ____ |
| Avoiding people ____ | Impulsivity ____ | Thoughts disorganized ____ |
| Chest pain ____ | Irritability ____ | Trembling ____ |
| Depression ____ | Judgment errors ____ | Withdrawing ____ |
| Disorientation ____ | Loneliness ____ | Worrying ____ |
| Distractibility ____ | Memory Impairment ____ | Other (specify) ____ |
| Dizziness ____ | Mood shifts ____ | _____ |
| Drug dependence ____ | Panic attacks ____ | _____ |
| Eating disorder ____ | Phobias/fears ____ | _____ |
| Elevated mood ____ | Recurring thoughts ____ | |

Please give examples of how each of the symptoms you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically). Use the back of this sheet if necessary.

60) List your five greatest strengths:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

61) List your five greatest weaknesses:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

62) List your main social difficulties:

63) List your main difficulties at school or work:

64) List your main difficulties at home:

65) List your behaviors you would like to change:

66) Additional information you believe would be helpful:

Please return this to the office at least two days before your next appointment.

