BIOLOGICAL INFORMATION-INTAKE FORM

Please fill out this biological background information as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPPA Notice of Privacy Practices. If you do not want to answer any question, leave the answer blank.

NAME:_____ **DATE:**_____

EMAIL (for invoice):_____ **D.O.B.**_____

ADDRESS:_____

TELEPHONE: Home:_____ **Cell:**_____

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

EMERGENCY CONTACT & PHONE:_____

REFERRAL SOURCE:_____

OCCUPATION:_____

Reasons for seeking treatment:_____

_____

CURRENT MARITAL STATUS:_____

SPOUSE/ PARTNER'S INFORMATION:

NAME:_____ **EDUCATION:**_____

OCCUPATION:_____

CHILDREN/STEP/GRAND:_____

_____

FAMILY HISTORY of ADDICTION, MENTAL ILLNESS, or VIOLENCE (including suicide, depression, hospitalizations in mental hospital, abuse, etc.):_____

_____

SIGNIFICANT/TRAUMATIC PERSONAL &/or FAMILY ILLNESS:_____

_____

MEDICATIONS:_____

PSYCHIATRIST NAME & CONTACT:_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE/TREATMENT:_____

_____

SUCIDE ATTEMPT(s) or VIOLENT BEHAVIOR (ages, reasons, circumstances, method):

_____

PSYCHIATRIC HOSPITALIZATIONS (Month & Year/ Reason):_____

_____

PAST/PRESENT PSYCHOTHERAPY (beginning & end dates; number of sessions; reason for therapy; individual/couple/family; was it helpful & how/why it ended):

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION(s)/ LAWSUIT(S)/ DIVORCE OR CUSTODY DISPUTES? (If yes, please explain):_____

_____

Please add any additional pertinent information:_____

_____

Signature & date:_____

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