Case #:_____

DX:_____

Biographical Information Form – Adult

To assist us in providing services to you, please complete this form as fully and openly as possible. All private information is held in the strictest confidence within legal limits. **If certain questions do not apply, leave them blank**. Some of the information is required by our accrediting and licensing agencies. **If you need help completing this form, please do not hesitate to ask.** Thank you for your cooperation.

REFERRED BY:_____

Today's Date:_____Birth Date:_____ Social Security #:_____

Name:_____ Age:_____ Gender: M F Race/Ethnicity:_____

Mailing Address: _____

Physical Address: (if different)_____

County:_____ City:_____ State:_____ Zip:_____

Do you live in a [ ] House [ ] Apartment [ ] Mobile Home [ ] Other _____

We may need to call you to remind you of an appointment or to change an appointment.

May we leave a message? Yes No (Please circle)

What is the best number to leave a message and contact you?_____

Annual Household Income:_____

Who currently lives in your household?

Name	Age	Relationship	Gender

What is/are the main reason for this visit?_____

_____

_____

OCCUPATIONAL

Current means of financial support (check all that apply):

[ ] Self [ ] Family [ ] Parents [ ] Spouse [ ] Children [ ] Retirement benefits [ ] Welfare [ ] Disability

Employment Status: [ ] employed full-time [ ] part-time [ ] unemployed [ ] disabled [ ] retired [ ] student

Current employer:_____Phone:_____

Your current position:_____Date Began:_____

YOUR CHILDREN

Name	Male/Female	Age

Who has custody of your children?_____

Are there custody issues or problems? [ ] Yes [ ] No If yes, please explain._____

_____

ABUSE HISTORY

Have you been a victim of any of the following types of abuse? If yes, please indicate by whom, the duration, and your age at the time of the abuse.

		By Whom?	Duration	Your Age
Physical Abuse	[ ] Yes [ ] No			
Sexual Abuse	[ ] Yes [ ] No			
Emotional Abuse	[ ] Yes [ ] No			
Neglect/Abandonment	[ ] Yes [ ] No			

Have you ever abused anyone? [ ] Yes [ ] No

If yes, please describe._____

_____

Have you ever been a victim of ANY other crime? [ ] Yes [ ] No

If yes, please describe._____

_____

Is there a family history of:

Substance abuse [ ] Yes [ ] No Describe_____

Suicide [ ] Yes [ ] No Describe_____

Violence [ ] Yes [ ] No Describe_____

Psychiatric Problems [ ] Yes [ ] No Describe_____

Criminal Activity [ ] Yes [ ] No Describe_____

SUBSTANCE USE/HABITUAL BEHAVIOR

Do you use nicotine? [ ] Yes [ ] No Type: [ ] Cigarettes [ ] Cigars [ ] Smokeless

How long have you used nicotine?_____ How much per day?_____

Do you use alcohol? [ ] Yes [ ] No If yes, how frequent?_____

How much each time?_____

Type of use: [ ] Social [ ] Recreational [ ] Abusive [ ] Problematic [ ] Addicted

If you do not currently use alcohol have you in the past? [ ] Yes [ ] No If yes, how frequent?_____

How much each time?_____

Type of use: [ ] Social [ ] Recreational [ ] Abusive [ ] Problematic [ ] Addicted

Do you currently or have you in the past used street drugs or abused prescription drugs? [ ] Yes [ ] No

Details:_____

Do you have any other addictive or compulsive behaviors (eating, gambling, etc.)?_____

_____

MEDICAL HISTORY

Primary care physician:_____

Address:_____

Are you under the care of a psychiatrist: [ ] Yes [ ] No If so, whom:_____

Other important healthcare providers:_____

Please list any medical conditions?_____

_____

HOSPITALIZATIONS (PHYSICAL OR MENTAL HEALTH)

Hospital	Dates	Reason

OUTPATIENT MENTAL HEALTH TREATMENT

Facility/Therapist	Dates	Reason

Allergies:_____

MEDICATIONS

Medication	Dose	Reason	Prescribing Physician

RELIGIOUS/SPIRITUAL CONCERNS

What is your religious preference?_____

How important is spirituality/religion in your life?

Not at all				Somewhat					Extremely
1	2	3	4	5	6	7	8	9	10

Do you have any concerns related to spirituality or religion?_____

_____

_____

Is there anything else you would like the counselor to know that has not already been covered?