

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. All information is confidential as outlined in the Disclosure Statement. If you do not desire to answer any question, merely write "Do not care to answer."

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

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

ADDRESS: _____

E-MAIL ADDRESS: _____

TELEPHONE: H: _____ **W:** _____ **FAX:** _____

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

PERSON AND PHONE NO. TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____ **MAY I THANK THEM? Y / N Initial**

OCCUPATION (former. if retired):

INSURANCE Info: _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you...):

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

MARITAL STATUS: _____, **Live with someone:** _____

PAST & PRESENT MARRIAGE/S (years, names & statement on the nature of the relationships, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

PRESENT SPOUSE (if married): **Education:** _____ **Occupation:** _____

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

1. _____

2. _____

- 3. _____
- 4. _____
- 5. _____
- 6. _____

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

Father: _____

Mother: _____

–
Step-parents: _____

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

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

MEDICAL DOCTOR/S (name /phone):

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

Specify all MEDICATION you are presently taking and for what: _____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

SUICIDE ATTEMPT/S (describe your age, reasons, how, etc.):

FAMILY MEDICAL HISTORY (Describe any illness that ran in the family: cancer, epilepsy, etc):

TRAUMAS: Please list and describe any traumas. These may include things like accidents, assaults, major illnesses, auto accidents, birth issues, etc., and symptoms you have.

PAST/PRESENT PSYCHOTHERAPY (dates, estimated no. of sessions, name of therapist, phone & address, initial reason for therapy, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

3. _____

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, METAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

LIFESTYLE (Please list exercise & frequency, supplements, amount & quantity of sleep, general diet, amount and frequency of alcohol, caffeine and cigarettes.):

Add here any other information that you would like me to know, below or on the back: