



DISCOVERY COUNSELING AND ASSESSMENT CENTER

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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: Home: _____ Cell: _____ Other: _____

FOR ROUTINE MESSAGES: Phone # _____ E-mail: _____

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

CURRENT: Marital status: _____ Live with someone: _____ Name: _____ Years: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & PHONE NO. TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATION (former. if retired): _____

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

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

MEDICAL DOCTOR/S (name /phone): _____

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

SPECIFY MEDICATION you are presently taking and for what. **PRINT** clearly:

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

SUICIDE ATTEMPT/S or **VIOLENT BEHAVIOR** (describe: ages, reasons, circumstances, how, etc.)

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

SPIRITUALITY (Describe quality, frequency, activities, etc.):

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

1. _____
2. _____
3. _____

USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

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 and fears?
