# Biographical Information – Intake Form

***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 and PLACE OF BIRTH: _________________________ AGE: _________
_

ADDRESS: _________________________________________________________________

TELEPHONES: H: ______ Cell: _________ Work/Off: ________ Fax: ___________________

FOR ROUTINE MESSAGES: Phone #______________ Email: ________________________

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #___________ Email: _____________

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: Mild ____ Moderate ____ Severe ___Very severe ____

CURRENT: Marital status: ____ Live with someone: ____ Name: ______________Years: ____
PAST & PRESENT MARRIAGE/S (names, years together, and statement about the nature of the relationship(s), i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

PRESENT SPOUSE/PARTNER: Education: _________________________________________
Occupation: _________________________________________________________________

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

1. _________________________________________________________________________
2. _________________________________________________________________________
3. _________________________________________________________________________

PARENTS/STEPPARENTS (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father:__________________________________________________________________________

Mother: _________________________________________________________________________

Stepparents:_____________________________________________________________________

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1.
2.
3.

MEDICAL DOCTOR (S) (name/phone): __________________________________________________

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

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: e.g., cancer, epilepsy, etc):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

PAST/PRESENT PSYCHOTHERAPY (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 PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

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

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):
Facebook: ______ YouTube: ______ Gaming: ______ Texting: ______ Browsing: ______
Work/School: ______ Other: ______

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

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?

What are your most important hopes or dreams?

# Signature on File

I understand that I am responsible for my bill.
I authorize use of this form for all my insurance submissions.
I authorize release of necessary information to all my insurance companies.
I authorize Anxiety & Stress Center, P.C. and its billing service to act as my agent in helping me obtain payment from my insurance companies.
I authorize direct payment to Anxiety & Stress Center, P.C.
I permit a copy of this authorization to be used in place of the original.
I understand that if my insurance does not pay for services rendered, I am responsible for my entire bill.

SIGNATURE______________________________ DATE____________________

# Coordination of Care

In an effort to coordinate your care, we routinely correspond with referring and treating physicians, including primary care physicians, gynecologists, internists, psychiatrists, and others. Please fill out the form below so that we may send summaries of treatment to your physician. Your signature below gives us permission to correspond with your treating physician while you are receiving services at the Anxiety & Stress Center, P.C. You may revoke this permission at any time.

Physician's Name _____________________________________________________

Address_____________________________________________________________

____________________________________________________________________
city                                                  state                    zip

Phone (        )________________________Fax (        )_______________________

Signature__________________________________Date_______________________

*Please add, on to this page, any other information you would like me to know about you and your situation.*