Office of Judith Smithchild
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Biographical Information Form—Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Demographics Today's Date: ________________________

1) Name: ______________________________________ 2) Age: ________ 3) DOB: _______________

3) Gender: __M ___F __Transgender __in Trans. Sexual identity: __Hetero. __ Gay __Lesbian __ Bi-sexual

4) Home Address: ____
Street & Number City State Zip

College Address: ____
Street & Number City State Zip

5) Weight: _________ 6) Height: _____ 7) Eye color: _________ 8) Hair color: ______________ 9) Race: __________

10) Ethnicity _____________ 11) Years of education: ______ If currently a student: College: ________________________
Year: _________ Major ____ Expected graduation date: ______________

12) Occupation: ____

13) Employer: _______________________________________ How long ?: ____________ Problems ?: ___ yes ___ no
Position: _______________________________________ Responsibilities: __________________________________
____

14) Cell ____________________________ Home Phone:_____________________ 15) Business _____________________

Email address ____ May we email/text you information? ____yes ____no

Emergency Contact Person Name: _____________________________________ Phone number: ______________________

Personal History

16) Present Marital / Partnership and Relationship Status:
_____ 1) never married _______ 5) currently separated
_____ 2) engaged to be married _______ 6) divorced, not remarried
_____ 3) married now or in a domestic partnership _______ 7) widowed
_____ 4) number of marriages/partnerships ________ _______ 8) other (specify) _____________

17) If married or in LT relationship are **you living with** your spouse/partner at present? Yes____ No____

18) If married/LT relationship, # of years : _____ Spouse/partner name:_____________________________ Age:_______
Spouse's employment: ____ Years: _________
Children's names and ages: ____
Are children or partner currently involved in counseling? Yes _____ No ______
Describe your main love, relationship, and/or family difficulties: ____
____
____

Counseling History

19) How did you hear about this office, or who referred you?: ______________________________________

20) Are you receiving counseling services at present?: No__ Yes __ Briefly describe: __________________________________

Have you had counseling in the past?: No ___ Yes___ Provider : ___________________________ Years of Service:_____

Issues addressed: ____ Past diagnosis: ______________________

22) What is (are) your main reason(s) for this visit?: ____

23) How long has this situation persisted ? (from #22): ____

24) Under what conditions does your situation/issues usually get worse? ____

25) Under what conditions does your situation/issue usually improve? ____

Medical History

26) Physician's name: ______________________ Physician's address: ____________________________________

27) List any major illnesses (ie. Diabetes, fibromyalgia, cancer, heart disease) and/or operations you have had:

____

____

28) List any physical concerns you are having at **presen**t: (e.g., high BP, headaches, diabetes, dizziness, etc.):

____

29) List any concerns you are experiencing or have experienced in the past that are chronic conditiond **(i.e., depression, anxiety, alcoholism, drug, sex, or gambling addiction, eating disorders, obsessive compulsive behaviors, etc.)**

____

____

30) When was your most recent complete physical exam?: ___________

Results of physical exam: ____

31) On average how many hours of sleep do you get daily?: _____

32) Do you have trouble falling asleep or staying alseep at night?: Yes ____ No _____

33) Have you gained/lost over ten pounds in the past year?: No __ Yes ____ gained __lost

If Yes, was the gain/loss on purpose?: __Yes __No

34) Describe your appetite (**during past week**): __ poor appetite __ average appetite ___ large appetite

Do you now or have you in the past had an eating disorder? No__ Yes ___

Describe: ____

Describe your eating and nutrition habits: ____

____

35) What medications (and dosages) are you taking at present, and for what purpose?

Please include any over the counter or health supplements in your list.

Medication	Dosage	Purpose

Describe your exercise habits and patterns: ____

____

Do you practice relaxation skills, meditation or Yoga? No _____ Yes _____ (Circle which ones)

Religious/Spirituality History

36) What is your present religious/spiritual affiliation?:
___ 1) Catholic ___ 2) Jewish ___ 3) Protestant (specify denomination if any) ____________________________
___ 4) None, but I believe in God ___ 5) Atheist or agnostic ___ 6) Other (please specify) __________________
37) How important is religious/spirituality commitment to you? : (Circle One)
Extremely important Important Average Unimportant Extremely unimportant
38) Do you desire to have your religious or spiritual beliefs and values incorporated into the counseling process? ___No ___Not sure ____ Yes _____ (If Yes, please explain) ____

Family History

39) Mother's age:____ If deceased, how old were **you** when she died?: _____
40) Father's age:____ If deceased, how old were **you** when he died?: ______
41) If your parents are separated or divorced, how old were **you** then? _______
If they remarried, Stepfather name: __________________ Step-mother name: ______________________
42) Number of brother(s) _____ Names and their ages: ____
43) Number of sister(s) _____ Names and their ages: ____
44) I was child number ______ in a family of ____ children.
45) Were you adopted or raised with parents other than your natural parents?: No___ Yes ___
Who were your primary caretakers: ____
46) Briefly describe your **current** relationship with your brothers and/or sisters:
____
Did you have step-brothers and step-sisters? No___ Yes ____
List names and their ages: ____
47) Which of the following best describes the family in which you grew up?:
WARM AND ACCEPTING AVERAGE HOSTILE AND FIGHTING
1 2 3 4 5 6 7 8 9

48) Which of the following best describes the way in which your family raised you?:
ALLOWED ME TO BE VERYINDEPENDENT AVERAGE ATTEMPTED TO CONTROL ME
1 2 3 4 5 6 7 8 9

YOUR MOTHER (or mother substitute) Name: ____
49) Briefly describe your mother: ____
50) How did she discipline you? ____
51) How did she reward you? ____
52) Your mother's occupation when you were a child: ____
53) How did you get along with your mother when you were a child _____ poorly _____ average _____ well
54) How do you get along with your mother **now**? _____ poorly _____ average _____ well
55) Did your mother have any problems (e.g., mental illness, alcoholism/addiction, violence, having affairs, gambling, etc.) that may have affected your childhood development?: Yes ________ No _______
(If Yes, please describe) ____
____
56) Is there anything unusual about your relationship with your mother?:
No ________ Yes ________ (please describe) ____

YOUR FATHER (or father substitute) Name: ____
57) Briefly describe your father (or father substitute) : ____
58) How did he discipline you?: ____
59) How did he reward you?: ____
60) Your father's occupation when you were a child: ____
61) How did you get along with your father when you were a child? _____ poorly _____ average _____ well
62) How do you get along with your father now? ____ poorly _____ average _____ well

63) Did your father have any problems (e.g. mental illness, alcoholism/addiction, violence, having affairs, gambling, etc.) that may have affected your childhood development?: Yes________ No________ (If Yes, please describe)
____
____

64) Is there anything unusual about your relationship with your father?: No ______ Yes ______
(If Yes, please describe) ____
____

65)What was the greatest positive impact your family made on you?
____

66) What was the greatest negative impact your family made on you?
____

67) List your three greatest personal strengths:
1) _________________________________
2) _________________________________
3) _________________________________

70) List your three greatest weaknesses
1) _________________________________
2) _________________________________
3) _________________________________

68) List your main social difficulties growing up: ____
List your current social difficulties: ____
Do you have a best friend? Yes___ No ___ Do you have friends you spend time with? Yes___ No ____
Do you use Facebook, Twitter, Linked-In, etc. for social networking activities/connections? Yes ___ No ____
Do you have social anxiety? Yes ___ No ___ Or suffer from shyness? Yes ____ No ____
List any community groups that you are involved in: ____

69) Describe your recreational activities, hobbies and interests: ______________________________________
____

70) List your main difficulties at school or work: ____

71) List your main difficulties at home: ____

72) List traumas you have experienced in the past or are experiencing currently: ________________________
____
____
____

73) List any legal issues you are currently having or any that you may have experienced in the past. Please identify if you are currently on probation/parole with any court system:
____
____

74) **Psychotherapy** helps individuals to increase personal well-being, repair or restore family or close relationships, increase interpersonal effectiveness in job or social situations, and improve overall general functioning. List **YOUR** primary behaviors, thoughts or emotions that you would like to change using ***psychotherapy*** as the preferred method of intervention or as an adjunct intervention with other resources:

1.Thoughts:____

2.Emotions:____

3.Behaviors____

75) List any changes you have begun to make already to cope and identify the ways you are coping with current stress:

____

____

Symptoms

76) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

_____ aggression
_____ alcohol dependence
_____ anger
_____ antisocial behavior
_____ anxiety
_____ avoiding people
_____ chest pain
_____ depression
_____ disorientation
_____ distractibility
_____ dizziness
_____ drug dependence
_____ eating disorder
_____ elevated mood
_____ sexual acting out
_____ delusions
_____ compulsions
_____ guilt
_____over-spending
_____ lethargic

_____ fatigue
_____ hallucinations
_____ heart palpitations
_____ high blood pressure
_____ hopelessness
_____ impulsivity
_____ irritability
_____ judgment errors
_____ loneliness
_____ memory impairment
_____ mood shifts
_____ panic attacks
_____ phobias/fears
_____ recurring thoughts
_____ intimacy avoidance
_____ hallucinations
_____ obsessions
_____ homicidal thoughts
_____ lack of trust
_____ lack of self-care

____ sexual difficulties
____ sick often
____ sleeping problems
_____ speech problems
_____ suicidal thoughts
_____ thoughts disorganized
_____ trembling
_____ withdrawing from alcohol/drugs
_____ worrying
_____ gambling
_____ pornography
_____ infidelity
_____ internet usage
_____ restricting food intake
______ emotional affairs
______post trauma behaviors
______low self-esteem
______ manic states
______ adjustment difficulty to changes
______ Grief/loss/bereavement

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.).

____
____
____

77) Additional information you believe would be helpful for me to know about you in our work together:

____
____

78) Please check what you would mostly like your therapist to provide to you:

_____ Information
_____ Guidance
_____ Feedback
_____ Hope
_____ Support
_____ a safe, therapeutic place to talk
_____ Consistent appointments
_____ Homework assignments
_____ a new perspective
_____ Confidentiality
_____ Alternatives
_____ Respect
_____ Comfort

PLEASE BRING THIS FORM WITH YOU TO YOUR FIRST SESSION. Thank you for your effort and time.