

Office of Judith Smithchild
M.Ed., LPCC-S, LICDC-S
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: _____ Preferred pronoun: ___He ___She ___They 2) Age: _____ 3) DOB: _____

3) Gender identity: ___M ___F ___Trans ___Other Describe: _____
Affectional identity: ___Hetero ___Gay ___Lesbian ___Bi-sexual ___Queer ___Questioning ___Intersex ___Asexual ___Ally
___Pansexual/polysexual ___Two-spirited

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 **present**: (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:

- | | | |
|--|--|---|
| <input type="checkbox"/> aggression | <input type="checkbox"/> fatigue | <input type="checkbox"/> sexual difficulties |
| <input type="checkbox"/> alcohol dependence | <input type="checkbox"/> hallucinations | <input type="checkbox"/> sick often |
| <input type="checkbox"/> anger | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> antisocial behavior | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> hopelessness | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> avoiding people | <input type="checkbox"/> impulsivity | <input type="checkbox"/> thoughts disorganized |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> irritability | <input type="checkbox"/> trembling |
| <input type="checkbox"/> depression | <input type="checkbox"/> judgment errors | <input type="checkbox"/> withdrawing from alcohol/drugs |
| <input type="checkbox"/> disorientation | <input type="checkbox"/> loneliness | <input type="checkbox"/> worrying |
| <input type="checkbox"/> distractibility | <input type="checkbox"/> memory impairment | <input type="checkbox"/> gambling |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> mood shifts | <input type="checkbox"/> pornography |
| <input type="checkbox"/> drug dependence | <input type="checkbox"/> panic attacks | <input type="checkbox"/> infidelity |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> phobias/fears | <input type="checkbox"/> internet usage |
| <input type="checkbox"/> elevated mood | <input type="checkbox"/> recurring thoughts | <input type="checkbox"/> restricting food intake |
| <input type="checkbox"/> sexual acting out | <input type="checkbox"/> intimacy avoidance | <input type="checkbox"/> emotional affairs |
| <input type="checkbox"/> delusions | <input type="checkbox"/> hallucinations | <input type="checkbox"/> post trauma behaviors |
| <input type="checkbox"/> compulsions | <input type="checkbox"/> obsessions | <input type="checkbox"/> low self-esteem |
| <input type="checkbox"/> guilt | <input type="checkbox"/> homicidal thoughts | <input type="checkbox"/> manic states |
| <input type="checkbox"/> over-spending | <input type="checkbox"/> lack of trust | <input type="checkbox"/> adjustment difficulty to changes |
| <input type="checkbox"/> lethargic | <input type="checkbox"/> lack of self-care | <input type="checkbox"/> 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.