

Revised 2/12/18

***NewPoint of View Counseling PLLC***

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**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: \_\_\_\_\_ Text: \_\_\_\_\_

HIGHEST GRADE/DEGREE: \_\_\_\_\_ TYPE OF DEGREE: \_\_\_\_\_

PERSON & PHONE NO. TO CONTACT IN EMERGENCY: \_\_\_\_\_

**REFERRAL SOURCE:** \_\_\_\_\_

**OCCUPATION** (former, if retired): \_\_\_\_\_

**What is your reason for deciding to seek treatment: (presenting problem)?**

**History of present problem:** (be as specific as you can: symptoms, when did it start, how long since you have had these symptoms, how often, how does it affect you)?

**Estimate the severity of above problem:** Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ Very severe \_\_\_\_\_?

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**Past psychiatric history:** (prior treatment, symptoms, diagnoses, hospitalization, suicide attempts, self-harming behavior, cutting)?

**Trauma History:** (physical, sexual, mental, when, persons involved)?

**Family psychiatric History:** (History of mental illness in family, diagnoses)?

**Medical Conditions & History:** (Current and past medical conditions, surgeries, accidents, falls, illnesses, treatments, allergies, etc)?

**Specify medications you are currently taking:** (prescribed and over the counter medications)

**Medical Doctor:** (S) (name/phone)?

**Substance Use:** (What substance (s), start date, last use, amount, frequency, attempts to stop or cut down)?

**Family History:** (Family of origin, relationship with parents, siblings, significant others)?

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**Social History:** (Significant relationships, social support, nature/quality of relationships)?

**Current:** Marital status: \_\_\_\_ Live with someone: \_\_\_\_ Name: \_\_\_\_\_ Years: \_\_\_\_

**Developmental History:** (Developmental milestones, delays)?

**Educational /Occupational History:** (Level of education, current, past employment etc)?

**Legal History:** (Arrest history, sentencing, Dui occurrences, incarceration, litigation)?

**Strengths / Limitations:**

**Other information that could be relevant to your treatment:**

**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 or partner name:** (Education/occupation)?

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**Friendships, community & spiritual supports:**

**Describe your childhood in general:** (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent)

**Estimate how many hours/day you spend online:** (Facebook, YouTube, internet gaming, texting, browsing, dating sites, internet pornsites.)?

Facebook: \_\_\_\_\_ YouTube: \_\_\_\_\_ Gaming: \_\_\_\_\_ Texting: \_\_\_\_\_ Browsing: \_\_\_\_\_  
Work/School: \_\_\_\_\_ Other: \_\_\_\_\_

**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?**

*Please add, on the other side of the page or on a separate page, any other information you would like me to know about you and your situation.*