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NewPoint of View Counseling

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Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. The information you provide to the following may help me understand your situation. Please be aware that this *Info* will be kept in your *Record* which may be accessed by your insurance carrier. If there is any *Info* you want me to have but are uncomfortable entering it into your *Record*, leave those items blank. You may share it with me during our 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)?

Was there an event which made these issues or problems surface? Y N

If yes, please describe:

_____

PLEASE INDICATE HOW YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Marriage/relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A
Anxiety Level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Sexual Functioning	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to Control Temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A
Eating Habits	1	2	3	4	5	N/A
If affected, describe how: _____						
_____						
Sleeping Habits	1	2	3	4	5	N/A
If affected, describe how: _____						
_____						

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ___Very severe ____?

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

Have you ever received **psychological or behavioral health** treatment of any kind before? Y N

If yes, please answer the following:

What type of care did you receive? Inpatient (hospital) Outpatient Both

When were you in treatment? _____

Where were you in treatment? _____

How long were you in treatment? _____

Who was your therapist or doctor? _____

Did your doctor prescribe medicine at that time? Y N

If yes, what was prescribed (include dosages if known)? _____

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)?

SUBSTANCE USE HISTORY

How often do you use:

	Never	Monthly	Weekly	Daily
Alcohol				

Cocaine _____

Hallucinogens (i.e. LSD) _____

Inhalants (i.e. paint) _____

Marijuana _____

Methamphetamine _____

Narcotics (i.e. heroin) _____

Over-the-counter drugs _____

Tobacco _____

Coffee/Soda _____

# of cups/cans _____

Other _____

Have you ever received substance abuse treatment of any kind before? Y N

Have you ever felt you had a problem with, or thought you ought to cut down on, your drinking or drug use? Y N

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

FAMILY BACKGROUND (include step-parents if applicable)

	Name	Age (or deceased)	Level of Education	Occupation
Father				
Mother				
Siblings				

	Yes/No	When?	Whom?
Have your parents ever been divorced?			
Have either of your parents ever had a problem with alcohol or drugs?			
Was there any physical or sexual abuse in your family?			
Are you in contact with your parents?			
Are you in contact with your siblings?			

Describe any medical or psychiatric conditions of your parents and siblings (including substance abuse):

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)?

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.