Blue Water Serenity 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 AND PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: H: _____ Cell: _____ Work: _____

FOR ROUTINE MESSAGES: Phone #_____ Email: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ Email: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

EMERGENCY CONTACT NAME AND NUMBER: _____

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: _____ Gaming: _____ Texting: _____ Browsing: _____
Work/School: _____ Other: _____

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?

_____

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.

Adult Symptom Checklist

Name:_____ Age:____ Date:_____

	Never	Rarely	Sometimes		Always	
Depression	0	1	2	3	4	5
Crying Spells	0	1	2	3	4	5
Hopelessness	0	1	2	3	4	5
Worthlessness	0	1	2	3	4	5
Trouble Falling Asleep	0	1	2	3	4	5
Interrupted Sleep	0	1	2	3	4	5
Awake Too Early	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5
Loss of Appetite	0	1	2	3	4	5
Overeating	0	1	2	3	4	5
Weight Loss/Gain # of Lbs	0	1	2	3	4	5
Lack of Interest	0	1	2	3	4	5
Suicidal thoughts	0	1	2	3	4	5
Homicidal Thoughts	0	1	2	3	4	5
Anxiety/Nervousness	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Mood Swings	0	1	2	3	4	5
Racing Thoughts	0	1	2	3	4	5
Difficulty Concentrating	0	1	2	3	4	5

Fatigue	0	1	2	3	4	5
Burst of Energy	0	1	2	3	4	5
	Never	**Rarely**		**Sometimes**		**Always**
Worrying	0	1	2	3	4	5
Fears of Ordinary Thing	0	1	2	3	4	5
For example crowds, germs, flying, doctors, closed spaces						
Yelling/screaming	0	1	2	3	4	5
Hard to Relax	0	1	2	3	4	5
Periodic Overspending	0	1	2	3	4	5
Gambling	0	1	2	3	4	5
Alcohol Problem	0	1	2	3	4	5
Drug Problem	0	1	2	3	4	5
Blackouts	0	1	2	3	4	5
Anxiety/Panic Attacks	0	1	2	3	4	5
Sexual Difficulties	0	1	2	3	4	5
Relationship Problems	0	1	2	3	4	5
Work Problems	0	1	2	3	4	5
Eating Disorders	0	1	2	3	4	5
Paranoia	0	1	2	3	4	5
Feeling Controlled	0	1	2	3	4	5
Domestic Violence	0	1	2	3	4	5
Hearing Voices Others Don't	0	1	2	3	4	5
Seeing Things Others Don't	0	1	2	3	4	5

Difficulty Controlling Thoughts	0	1	2	3	4	5
Inability to Finish Tasks	0	1	2	3	4	5

Substance Use Checklist

Substance	**How Much?**	**How Often?**	**Year 1st Used?**	**Last Used?**
Tobacco				
Alcohol				
Sleeping Pills				
Marijuana				
Inhalants				
Cocaine/Crack				
Heroin				
Prescription Pain Meds				
Valium/Xanax				
Ecstacy				