Bibliographical Information Form

Date: ____________________

Identifying Information

Name: ____

Date of Birth: ____

Marital Status: ____

Home Phone: ____

Cell Phone: ____

Email: ____

Address: ____

Emergency contact(name/phone):____

Symptoms (please mark/circle all that apply)

- Childhood issues
- Compulsions
- Dependence
- Depression, low mood, sadness, crying
- Divorce/separation
- Drug/Alcohol use—prescription medications, over the counter medications, street drugs
- Eating problems—over eating, appetite, vomiting, restricting, etc
- Emptiness
- Feelings of failure
- Fears, phobias
- Gambling
- Relationships/friendships/interpersonal conflicts
- Grieving, mourning, deaths, losses
- Health, illness, medical concerns, physical problems
- Impulsiveness, loss of control, outbursts
- Judgement problems
- Loneliness
- Marital/relationship conflict, distance coldness, infidelity/affairs, differing expectations
- Mood swings
- Nervousness/tension
- Obsessions, compulsions (thoughts or actions that repeat themselves
- Panic or anxiety
- Parent/child relationships, child management, discipline
- Self Esteem, self-neglect, poor self esteem
- Sexual issues, dysfunctions, conflicts, desire differences
- Sleep problems (please describe)
- Suspiciousness, distrust

- Suicidal thoughts, ideations
- Weight and diet issue
- Withdrawal, isolation
- Work problems, employment, overworking, unemployed/unemployable, dissatisfaction
- Other concerns/recent life changes: ____

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Prior Treatment

Dates: ____

Problem: ____

Therapist/clinic/phone number: ____

Family of Origin

Father:

Mother:

Siblings:

Step-Parents:

Grandparents:

Others:

Childhood Issues and Experiences (please describe): ____

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____

Current Household

Current partner/spouse: ____

Mental health/personality: ____

Children (names, ages, living in home or out, personality or mental health issues: ____________________________

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Relationship History

Marital/relationship history (names, ages, length of relationships, other issues, please describe):

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Educational and Occupational History

The patient is currently (please circle): employed/full-time/part-time/unemployed/in school

Education:

Major or favorite subject:

Working/education hours per week:

Work field:

Current or most recent job title:

Likes/dislikes about employment/school:

Home Life

Personal time (hobbies, clubs, family activities, etc.):

Monthly contacts with friends:

Discuss feelings/private matters with:

Health

Accidents or illness:

Other chronic health problems:

Average sleep hours per night:

Drinks consumed per week:

Recreational drugs in last year:

Exercise:

Tobacco use:

Primary care provider/phone number:

Last physical:

Concerned about health?

Healthcare drugs and purpose:

Accomplishments / Additional Information

Strengths and accomplishments: ____

____
____
____

Is there anything else you think I need to know? ____

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