

# 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.

## Personal History

- 1) Name: \_\_\_\_\_ 2) Age: \_\_\_\_\_ 3) Gender: \_\_\_M\_\_\_F  
4) Address: \_\_\_\_\_  
                                Street & Number                                  City                                  State                                  Zip  
5) Weight: \_\_\_\_\_ 6) Height: \_\_\_\_\_ 7) Eye color: \_\_\_\_\_ 8) Hair color: \_\_\_\_\_ 9) Race: \_\_\_\_\_  
10) Today's Date: \_\_\_\_\_ 11) Date of Birth: \_\_\_\_\_ 12) Years of education: \_\_\_\_\_  
13) Occupation: \_\_\_\_\_ 14) Home Phone: \_\_\_\_\_ 15) Business Phone: \_\_\_\_\_  
16) Present Marital Status:                                  15a) Cell Phone: \_\_\_\_\_  
\_\_\_\_ 1) never married                                  \_\_\_\_\_ 5) separated  
\_\_\_\_ 2) engaged to be married                                  \_\_\_\_\_ 6) divorced and not remarried  
\_\_\_\_ 3) married now for first time                                  \_\_\_\_\_ 7) widowed and not remarried  
\_\_\_\_ 4) married now after first time                                  \_\_\_\_\_ 8) other (specify) \_\_\_\_\_

- 17) If married, are you living with your spouse at present?: Yes \_\_\_\_\_ No \_\_\_\_\_  
18) If married, years married to present spouse: \_\_\_\_\_

## Counseling History

- 19) Are you receiving counseling services at present?: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, please briefly describe: \_\_\_\_\_  
\_\_\_\_\_  
20) Have you received counseling in the past?: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes, please briefly describe: \_\_\_\_\_  
\_\_\_\_\_  
21) What is (are) your main reason(s) for this visit?: \_\_\_\_\_  
\_\_\_\_\_  
22) How long has this problem persisted (from #21)?: \_\_\_\_\_  
\_\_\_\_\_  
23) Under what conditions do your problems usually get worse?: \_\_\_\_\_  
\_\_\_\_\_  
24) Under what conditions are your problems usually improved?: \_\_\_\_\_  
\_\_\_\_\_  
25) How did you hear about this clinic, or who referred you?: \_\_\_\_\_  
\_\_\_\_\_

**Medical History**

- 26) Name and address of your primary physician:  
Physician's name: \_\_\_\_\_  
Address: \_\_\_\_\_
- 27) List any major illnesses and/or operations you have had: \_\_\_\_\_  
\_\_\_\_\_
- 28) List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc.): \_\_\_\_\_  
\_\_\_\_\_
- 29) List any other physical concerns you have experienced in the past: \_\_\_\_\_  
\_\_\_\_\_
- 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 at night?:  No  Yes If Yes, describe \_\_\_\_\_  
\_\_\_\_\_
- 33) Have you gained/lost over ten pounds in the past year?:  Yes  No,  gained  lost  
If Yes, was the gain/loss on purpose?:  Yes  No
- 34) Describe your appetite (during the past week):  
 poor appetite  average appetite  large appetite
- 35) What medications (and dosages) are you taking at present, and for what purpose?:  

<u>Medication</u>	<u>Purpose</u>
_____	_____
_____	_____
_____	_____
_____	_____

**Religious Concerns**

- 36) What is your present religious 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 commitment to you?:  

Unimportant			Average			Extremely
1	2	3	importance	4	5	important
					6	7
- 38) Do you desire to have your religious beliefs and values incorporated into the counseling process?:  
 Yes  No  Not sure (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?: \_\_\_\_\_
- 42) Number of brother(s) \_\_\_\_\_ Their ages \_\_\_\_\_
- 43) Number of sister(s) \_\_\_\_\_ 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?: Yes \_\_\_ No \_\_\_
- 46) Briefly describe your relationship with your brothers and/or sisters: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 VERY INDEPENDENT				AVERAGE				ATTEMPTED TO CONTROL ME
1	2	3	4	5	6	7	8	9

**YOUR MOTHER** (or mother substitute)

49) Briefly describe your mother: \_\_\_\_\_

\_\_\_\_\_

50) How did she discipline you?: \_\_\_\_\_

\_\_\_\_\_

51) How did she reward you?: \_\_\_\_\_

\_\_\_\_\_

52) How much time did she spend with you when you were a child?: \_\_\_\_\_

\_\_\_\_\_ much \_\_\_\_\_ average \_\_\_\_\_ little

53) Your mother's occupation when you were a child: \_\_\_\_\_

\_\_\_\_\_ stayed home \_\_\_\_\_ worked outside part-time \_\_\_\_\_ worked outside full-time

54) How did you get along with your mother when you were a child?:

\_\_\_\_\_ poorly \_\_\_\_\_ average \_\_\_\_\_ well

55) How do you get along with your mother now?:

\_\_\_\_\_ poorly \_\_\_\_\_ average \_\_\_\_\_ well

56) Did your mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development?: Yes \_\_\_\_\_ No \_\_\_\_\_  
(If Yes, please describe)\_\_\_\_\_

57) Is there anything unusual about your relationship with your mother?:  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If Yes, please describe) \_\_\_\_\_

58) Describe overall how your mother treated the following people as you were growing up:  
**(Circle one answer for each)**

YOUR MOTHER'S TREATMENT OF:	Poor			Average			Excellent	
1) YOU	1	2	3	4	5	6	7	
2) YOUR FAMILY	1	2	3	4	5	6	7	
3) YOUR FATHER	1	2	3	4	5	6	7	

**YOUR FATHER** (or father substitute)

59) Briefly describe your father:\_\_\_\_\_

60) How did he discipline you?:\_\_\_\_\_

61) How did he reward you?:\_\_\_\_\_

62) How much time did he spend with you when you were a child?:  
\_\_\_\_\_ much \_\_\_\_\_ average \_\_\_\_\_ little

63) Your father's occupation when you were a child: \_\_\_\_\_  
\_\_\_\_\_ stayed home \_\_\_\_\_ worked outside part-time \_\_\_\_\_ worked outside full-time

64) How did you get along with your father when you were a child?: \_\_\_\_\_  
\_\_\_\_\_ poorly \_\_\_\_\_ average \_\_\_\_\_ well

65) How do you get along with your father now?:  
\_\_\_\_\_ poorly \_\_\_\_\_ average \_\_\_\_\_ well

66) Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development?: Yes \_\_\_\_\_ No \_\_\_\_\_  
(If Yes, please describe)\_\_\_\_\_

67) Is there anything unusual about your relationship with your father?: No \_\_\_\_\_ Yes \_\_\_\_\_  
(If Yes, please describe)\_\_\_\_\_

68) Describe overall how your father treated the following people as you were growing up:  
**(Circle one answer for each)**

YOUR FATHER'S TREATMENT OF:	Poor			Average			Excellent	
1) YOU	1	2	3	4	5	6	7	
2) YOUR FAMILY	1	2	3	4	5	6	7	
3) YOUR MOTHER	1	2	3	4	5	6	7	





71) List your five greatest strengths:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

72) List your five greatest weaknesses:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

73) List your main social difficulties: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

74) List your main love and sex difficulties: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

75) List your main difficulties at school or work: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

76) List your main difficulties at home: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

77) List your behaviors that you would like to change: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

78) Additional information you believe would be helpful: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print Name of Person Completing Form

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date