

Biographical Information – Adult

Instructions: Please fill out this form as fully and openly as possible. All information is held in strictest confidence within legal limits. If certain questions do not apply, leave them blank.

Today's Date: _____ Client's Name: _____

Personal History

1. Have you previously been involved in therapy/counseling? ____ Y ____ N

If yes, please describe what worked, what didn't:

2. Why are you coming to therapy?

3. How long has this issue be going on ? _____

4. Under what conditions does the issue/problem get worse? _____

5. Under what conditions does the issue/problem get better? _____

Family History

6. Place of your birth: _____

7. Adopted? _____ 8. Foster homes? _____

9. Siblings – brothers: _____ sisters: _____ birth order: _____

10. Parents: ____ married ____ divorced - when? _____

11. What is/was their relationship like? _____

12. Parent – ____ living ____ deceased 13. Age, current or at death: _____

14. Your age at this parent's death or when you left home? _____

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15. How did this Parent relate to you as a child? _____
16. How does this Parent relate to you now? _____
17. Other Parent – _____ living _____ deceased 18. Age, current or at death: _____
19. Your age at this Parent's death or when you left home? _____
20. How did this Parent relate to you as a child? _____
21. How does this Parent relate to you now? _____
22. How much contact do you have with your family of origin and how satisfying is it? _____

23. Briefly describe any problems in your mother's pregnancy and/or your birth: _____

24. List any drugs used by your parents at your conception, and mother at time of pregnancy:

25. Please describe any physical, emotional, or sexual abuse you may have experienced as a child:

26. Please describe any physical, emotional, or sexual abuse you may have experienced as an adult: _____

27. What is your current relationship status? _____ married _____ long-term partnership
_____ divorced _____ separated _____ widow/widower _____ single
28. How many times married/partnered? _____ 29. How many significant relationships? _____
30. Describe what has worked in your relationships: _____

31. Describe what has been difficult in relationships: _____

32. Children: Name _____ Age _____ Sex _____ Live with you? _____ Bio/Adopted _____
(old to Name _____ Age _____ Sex _____ Live with you? _____ Bio/Adopted _____
young) Name _____ Age _____ Sex _____ Live with you? _____ Bio/Adopted _____
 Name _____ Age _____ Sex _____ Live with you? _____ Bio/Adopted _____
33. How have you related to them in the past? _____
34. How do you relate to them now? _____
35. Please describe each child's birth or adoption story: _____

36. Were your children's arrivals in your life planned or unplanned? Please specify: _____

37. How did you feel when each child joined your family? Please specify child's initials/name: _____ happy
_____ sad _____ angry _____ confused _____ surprised _____ rejecting _____ accepting _____ bonded
_____ unbonded

38. How do you feel about each child now? Please specify child's initials/name: _____ happy _____ sad
_____ angry _____ confused _____ surprised _____ rejecting _____ accepting _____ bonded _____ unbonded

39. Briefly describe the style of parenting used in the household: _____

40. List biggest challenges as a parent: _____

41. List biggest joys as a parent: _____

42. Do any family members have a history of physical or mental illness, including substance abuse?
Who? _____
What illness(es)? _____

43. What is your current spiritual path? _____

44. Who are most important people in your life now? _____

Medical History

45. Primary Care Physician's Name: _____

46. Physician's contact information:
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: _____

47. Most recent physical exam date: _____ 60. Results: _____

48. Names of other significant health professionals: _____

49. List any major illnesses and/or operations: _____

50. List any physical concerns occurring at present: (e.g., high blood pressure, headaches) _____

51. List any physical concerns in past: (e.g., head injury, _____

seizures) _____

52. List any emotional concerns occurring at present: (e.g., crying, fearful)

53. List any emotional concerns in past: (e.g., angry, timid) _____

54. Do you have a history of psychiatric hospitalizations? ____N ____Y
If yes, where and when? _____

55. Do you have a history of suicidality/homicidality or self-harming behaviors? ____N ____Y
If yes, please describe: _____

56. On average, how many hours do you sleep daily? _____

57. Do you have trouble falling asleep at night? ____N ____Y
If yes, how long has this been a problem? _____

58. Do you have any nightmares or significant dreams? ____N ____Y
If yes, please describe: _____

59. Describe your current appetite: ____Poor ____Average ____Large
Is this atypical? ____N ____Y

60. How many meals/snacks do you eat per day? _____

61. Does your family eat together? _____

62. What medications, vitamins, and herbs (and dosages) are you taking at present, and for what purposes?

63. Do you have a history of substance abuse? ____Y ____N
If yes, describe behaviors, substances, degree of impact on life, coping tools: _____

Emotional and Behavioral History

64. What are you happy/satisfied about in your life? _____

65. What do you really want to change in your life? _____

66. List your three greatest strengths:

1. _____
2. _____
3. _____

67. List your three greatest challenges or areas in need of improvement:

1. _____
2. _____
3. _____

68. What do you like? _____
Hobbies/interests? _____

69. What do you dislike? _____

70. Are you prone to periods of strong anxiety or panic attacks? If yes, describe: _____

71. Have you experienced severe mood swings or extended depressions? If yes, describe: _____

72. Do you have problems paying attention, staying with boring tasks? If yes, describe: _____

73. Do you or your friends/family consider you to have an anger problem? If yes, describe: _____

74. Describe how you express the following emotions/behaviors. What does your body do?

Anger: _____

Happiness: _____

Sadness: _____

Anxiety: _____

75. How do you seek attention? _____

76. How do you take care of yourself? _____

77. How much and what kind of physical activity/movement do you practice? _____

78. Is there anything else you would like to share? _____

Client Signature: _____

Therapist Signature: _____

Please remember to return this form to The Mariposa Center when complete. Thank you!