SUSAN E. SCHWARTZ, PH.D

Personal 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. 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 OF BIRTH/PLACE: ____ AGE: ________

ADDRESS: ____

____

TELEPHONE: H: ___________________ Cell: ____________________ W/Off: ___________________

FOR ROUTINE MESSAGES: Phone #______________________ E-mail: _________________________

FOR CONFIDENTIAL/PRIVATE MESSAGES:

Phone #____________________________ E-mail: ____

HIGHEST GRADE/DEGREE: _______________ TYPE OF DEGREE: __________________________

PERSON & PHONE NO. TO CALL IN EMERGENCY:

____

REFERRAL SOURCE:

OCCUPATION (former. if retired):

____

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Please describe why you are seeking help at this time (be as specific as you can: when did it start, how does it affect you...): ____

____

____

Family information

CURRENT: Marital status: __________________ Live with someone:_____________________________

Name: ____ Years: ______________________

PAST & PRESENT MARRIAGE/S (years together, statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile.) If divorced, reasons for divorce:

____

____

____

____

____

____

PRESENT SPOUSE/PARTNER: ____

Physical health

HOW DO YPOU RATE YOUR OVERALL PHYSICAL HEALTH?

Excellent__________ Great ___________ Good ___________ Fair__________ Poor___________

DO YOU HAVE ANY SLEEP PROBLEMS? Yes _________ No __________

If Yes, Please describe:

____

____

If you have/had medical problems, surgeries, accidents, falls, illness, please describe:
____

____

____

____

____

MEDICAL DOCTOR/S (name /phone): ____

PAST/PRESENT MEDICAL CARE (major SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:
____

____

____

Emotional health

HAVE YOU HAD ANY PROBLEM WITH ISSUES OF DEPRESSION, ANXIETY, ADD/ADHD OR ANY OTHER MENTAL OR EMOTIONAL DISORDER? If so, please describe:
____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):
____

____

____

____

HAVE YOU EVER SEEN A THERAPIST FOR EMOTIONAL PROBLEMS?
Please describe times, durations, outcomes:

____

____

____

____

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS?
If yes, please give information (dates, reasons, outcomes)

____

____

____

____

ARE YOU CURRENTLY EXPERIENCING SUICIDAL THOUGHTS?

____

____

HAVE YOU EVER TRIED TO COMMIT SUICIDE? If yes, please give details

____

____

____

____

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Family mental history

HAS ANY FAMILY MEMBER BEEN HOSPITALIZED FOR MENTAL HEALTH CONCERNS? Please give details

____

____

____

____

DOES YOUR FAMILY HAVE A HISTORY OF SUBSTANCE ABUSE? Please explain

____

____

____

____

HAS ANYBODY IN YOUR FAMILY ATTEMPTED OR COMMITTED SUICIDE? Please explain

____

____

____

____

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Legal history

ARE YOU CURRENTLY OR HAVE YOU IN THE PAST BEEN INVOLVED IN ANY CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (If you answer Yes, please explain):

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PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS THAT YOU HAVE:

Chronic sadness___ Crying episodes___ Hopelessness ___ Loss of appetite___
Difficulty concentrating___ Overeating___ Difficulty making decisions___
Low energy/fatigue___ Agitation___ Restlessness___ Irritability___ Excessive worry___ Fearfulness___
Trembling/shaking___ Excessive fears___ Intrusive thoughts___ Flashbacks___ Hearing voices___
Seeing things others don't see___ Ideas that others are talking about you/want to cause you harm___
Difficulty completing tasks___ Disorganized___ Difficulty focusing___ Tendency to act impulsively___
Problems with relationships___ Overwhelmed___ Racing thoughts___ Insomnia___ Hypersomnia___
Problems with memory___ Isolation___ Lack of enjoyment/pleasure___ Lack of interest in sex___
Difficulty functioning in relationships and at work___ Palpitations___ Shortness of breath___ Panic___
Nightmares___ Relational conflicts___ Domestic violence___

Thank you.

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