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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 or fax 1-512-206-0260.

DATE :_____

NAME: _____ **MALE/FEMALE:** _____

DATE OF BIRTH/PLACE: _____ **AGE:** _____

ADDRESS: _____

City: _____ **State:** _____ **Zip:** _____

TELEPHONE: H: _____ **Cell:** _____ **W/Off:** _____ **FAX:** _____

FOR ROUTINE MESSAGES: Phone #_____ **E-mail:** _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ **E-mail:** _____

HIGHEST GRADE/DEGREE: _____ **TYPE OF DEGREE:** _____

Occupation: _____

In case of emergency (name, relationship, phone):

1. _____
2. _____

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:

Partner:_____**Years:** _____

PARTNER's: Education: _____ **Occupation:** _____

Nature of your relationship:

_____

_____

_____

_____

PAST Partners (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

_____

_____

_____

_____

_____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1._____

2._____

3._____

4._____

5._____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

_____

Mother:_____

_____

_____

Step-

parents:_____

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____

2._____

3._____

4._____

5._____

MEDICAL DOCTOR/S (name /phone): _____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

_____

_____

_____

_____

SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> 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 <u>illness</u> that runs in the family: cancer, epilepsy, etc)**:**

_____

_____

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

_____

_____

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_____

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_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

Name: _____ **City/State:** _____

Beg Date: _____ **End Date:** _____ **Number os Sessions:** _____

Reason for therapy:_____

_____

Reason Therapy

Ended:_____

_____

Name: _____ **City/State:** _____

Beg Date: _____ **End Date:** _____ **Number os Sessions:** _____

Reason for therapy:_____

_____

Reason Therapy

Ended:_____

_____

Name: _____ **City/State:** _____

Beg Date: _____ **End Date:** _____ **Number os Sessions:** _____

Reason for therapy:_____

_____

Reason Therapy

Ended:_____

_____

On a separate sheet of paper, please write the answers to the following questions. Please be as thorough as you can with each question.

Family of Origin:

- Describe your mother and father (both strengths and weaknesses).
- How did your parents show affection to each other and their children?
- Describe your parent's marital history.
- Describe your parent's parenting philosophy.
- Describe your parent's means of motivation/discipline.
- Describe the communication style of your family of origin.
- How did your parent's handle disagreements and conflicts?
- How many siblings do you have and what role did each sibling play in family dynamics?
- Do you see any family patterns being repeated in your current family or in your siblings current families?
- Describe any changes in your family of origin, including: moves, job changes, significant events, deaths, separations from parents, divorce, major illness, or injuries.
- Describe your early childhood including any illnesses, hospitalizations, injuries, and separation from parents. Include significant memories, favorite activities, etc.

Current Family:

- Describe your current marriage/relationship (include both strengths and weaknesses).
- Write a brief description of any previous marriage(s).
- Describe your parenting philosophy.
- Describe your means of motivation/discipline.
- Describe any differences of parenting styles.
- Describe your communication styles.
- How are decisions made?
- Describe any current significant medical problems.
- List your children and give a brief description of each child.
- What concerns do you have with any other family member?
- Describe the family's support system.
- Describe your family's involvement with outside activities.
- How large of a role (if any) does religion play in your family?
- Describe your family's lifestyle.

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 goals for therapy?

_____

_____

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_____

INFORMED CONSENT:

Please provide the information requested below. Your signature will indicate that you understand and accept the information contained in the four-page document "Informed Consent Information".

Printed name: _____

Date of Birth:_____

Social Security Number: _____-_____-_____

Address:_____

City_____State_____Zip_____

Email Address:_____Ok to Email? _____

Home phone: _____ OK to leave message (Y/N)? _____

Work phone: _____ OK to leave message (Y/N)?_____

Who referred you to this practice? _____

May I thank your referral source (Y/N)? _____

Will you want receipts to file for insurance reimbursement (Y/N)? _____

This acknowledges that I have read the HIPPA Privacy Form and may request a copy for my files.

Signature:_____

Date:_____