Background Information Form

Name: _____ Date**:** _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Home Phone _____ Work Phone _____ Cell Phone_____

Email: _____

Any restrictions on messages left at the above numbers: _____

Marital Status: Single____ Engaged ____ Married ____ Separated ____ Divorced ____ Widowed _____

Occupation: _____ Employer: _____ Years at this job: _____

Emergency Contact: _____ Telephone #: _____

Referred by: _____

Insurance Information:

Insurance Company: _____ Policy #/ID: _____

Person responsible for payment (circle one): Self Spouse Parent Other: _____

Responsible party:

Name**:**_____ SSN: _____ DOB: _____

Address: _____ Employer Name:_____

Health Information:

Rate your health: Very good _____ Good _____ Average _____ Declining _____ Poor _____ Other _____

Physician _____ Phone Number _____

Date and results of last physical exam _____

Your approximate height and weight _____ Any recent weight changes? _____

List any significant present or past illnesses, injuries, or handicaps _____

_____

_____

Please list all medications currently taken: Reason for taking:

_____

_____

_____

_____

_____

Do you drink alcoholic beverages? Yes ___ No ___ If Yes, how much/often? _____

Do you smoke? Yes _____ No _____ What? _____ Frequency?_____

How many caffeine drinks do you consume daily? _____

Have you ever been to a counselor before? Yes _____ No _____

Have you ever been hospitalized for psychological problems? Yes _____ No _____

Have you ever attempted suicide? Yes _____ No _____

Has a relative or close friend ever attempted or committed suicide? Yes ____ No _____

Religious and Spiritual Information:

Denominational Preference _____ Member? Yes _____ No _____

Spouse's Denominational Preference _____ Member? Yes _____ No _____

Attend services: Regularly _____ Occasionally _____ Never _____

Please list any religious/spiritual questions or problems that are of concern to you: _____

_____

Marital Information (if applicable):

Spouse's name _____ Age _____ Phone _____

Spouse's occupation _____

How long did you know each other before marriage? _____ Length of marriage: _____

Length of engagement _____ Ages when married: You _____ Spouse _____

List any prior separations from your spouse with date and reason: _____

_____

List any previous marriages: _____

Information about children from present or previous marriages:

Name	Age	Sex	Education	Marital Status	Biol./Adopted/Step

Family Information:

Are your parents living or deceased? Father _____ Mother _____

If living, present ages: Father _____ Mother _____

If deceased, age and cause of death: Father _____

Mother _____

Were your parents ever divorced or separated? Yes _____ No _____

If yes, how old were you and how did you react? _____

_____

List all of the children in your natural family, from oldest to youngest, including yourself:

Name	Age	Sex	Education	Marital Status	Career Status

Counseling Goals:

What problem(s) bring you to counseling at this time? _____

_____

_____

Describe when and how your problem(s) began: _____

_____

_____

How would you like to benefit from counseling? _____

_____

_____

_____

FOCUS AREAS

Circle each item that is of concern to you.

Anxiety	Difficulty trusting others	Weight loss/gain
Depressed Mood	Difficulty relaxing	Stomach/bowel disturbances
Guilt	Grief/Loss issues	Obsession with food/weight
Suicidal thoughts	Anger problems	Rely too much on others
Fear of conflict	Sexual problem/concerns	Fighting/arguing with others
Can't make decisions	Fears of things or situations	Shy/awkward with others
Headaches	Easily agitated or "on edge"	Bitterness/resentment
Lack of confidence	Fear of losing "control"	Forgiveness issues
Loneliness	"Pounding" heart or heart problems	Risky behavior
Suspicious of others	Alcohol/drug problems in family	Difficulty in dating relationships
Loss of interest in life	Drinking/drug issues	Difficulty with parents
Difficulty sleeping	Stress from recent events	Peer issues
Panic/Anxiety attacks	Divorce/separation	Marital issues
Nightmares/bad dreams	Financial Problems	Parenting issues
Troubling memories	Desire to hurt self or others	Gambling
Tiredness/Fatigue	Religious/spiritual concerns	Feelings of worthlessness
Hopelessness	Past/present abuse	Excess energy/hyperactivity
Racing thoughts	Obsessions/repetitive thoughts	Compulsive behavior
Uncontrollable worries	Difficulty concentrating	Other_____

I have completed the above information accurately and have read/agreed to the general information and policy statements of Leahan Doar, M.A., L.P.C.

_____ _____

Client Signature Date