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IDENTIFYING INFORMATION

Please fill out this biographical background form as completely as possible. It will help me in our work together. You can either email it back to me at drjeanneclevenger@gmail.com as an email attachment, or bring it with you to our first session. Information is confidential as outlined in the Consent form and Notice of Privacy Practices. Please type or write clearly.

Client Name: ____
(Last) (First) (MI)

Parent(s)/guardian(s) (if under 18 years): ______________________________
(Last) (First) (MI)

____

Birth Date: ______ /______ /________ Age: __________ Gender: □ Male □ Female

How do you identify, culturally (ethnicity, race, religion, etc.)? ______________________

____

Address: ____
(Number and Street)

____
(City) (State) (Zip)

Primary Phone: (_____)_________________ May we identify the clinic? □ Yes □ No

Secondary Phone: (_____)_________________ May we identify the clinic? □ Yes □ No

E-mail: ______________________________ May we email you? □ Yes □ No
**Please note: Email correspondence is NOT considered to be a confidential medium of communication.*

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/ages: ______________________________

Emergency Contact (Name/Phone): ______________________________

How did you hear about me? ______________________________

GENERAL HEALTH & MENTAL HEALTH INFORMATION

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 ____

Have you ever received any type of mental health services (psychotherapy, groups, testing/assessment, psychiatric services, etc.)? □ Yes □ No

Names/types of therapists/practitioners: ______________________________________

____

Current vitamins/supplements and/or prescribed medications, if any:

Name	How much?	How often?	Date began	Purpose

Current or previous prescribed psychiatric medication, if any:

Name	How much?	How often?	Date began/ended	Purpose

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: ______________________

____

Medical Doctor (Name/Phone): ____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: ______________________

____

3. How many times per week do you generally exercise? __________ Type: ________________

4. Please list any difficulties you experience with your appetite or eating patterns: _____________

____

5. Are you currently experiencing overwhelming sadness, grief, or depression? □ No □ Yes

If yes, for approximately how long? ____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this? _________________________________

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: ____

8. Do you drink alcohol more than once a week? □ No □ Yes

If yes, how often/amount: ____

9. How often do you engage recreational drug use? (please circle)

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? □ No □ Yes If yes, for how long? ____________

On a scale of 1 to 10 (10 being best), how would you rate your relationship? __________

11. What significant life changes or stressful events have you experienced recently?

____

____

PERSONAL AND FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history – including yourself – of any of the following. If yes, please indicate the family member's relationship to you in the space provided (self, father, grandmother, uncle, etc.).

	Please circle	**List Self or Family Member(s)**
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
Schizophrenia	Yes / No	
Suicide Attempts	Yes / No	
Violent/Assaultive Behavior	Yes / No	
Other (Describe)		

HISTORY

1. Briefly describe or list significant events from your CHILDHOOD (e.g., relationship with parents, siblings, divorce, school/behavioral problems, moves, trauma):

____

____

2. Briefly describe or list your SOCIAL SUPPORT (e.g., friendships, spiritual community):

____

____

3. Briefly describe or list your EDUCATION (e.g. highest grade/degree, academic performance/interests):

____

____

4. 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):

____

____

ADDITIONAL INFORMATION

1. Do you currently have employment/source of income? □ No □ Yes

Please describe: ____

2. Do you enjoy your work? Is there anything stressful about your current work? ____________

____

3. What do you consider to be some of your strengths? ___________________________

____

4. What do you consider to be some of your weaknesses? ___________________________

____

5. What would you like to accomplish out of your time in therapy? ____________________

____