

DEPRESSION & ANXIETY DISORDERS TREATMENT CENTER

A SUBSIDIARY OF PSYCHOLOGICAL ASSESSMENT & TREATMENT SPECIALISTS, INC.

BIOGRAPHICAL DATA FORM © 2008

Please complete this form to the best of your ability. Feel free to use the reverse side of the pages to provide more in depth information.

Date: _____ Referred to DADTC by: _____

This form was completed by: _____



I. DEMOGRAPHICS

Name: _____ Age: _____ DOB: _____
Address: _____ Home Phone: _____

Family Members (OF THE FAMILY YOU GREW UP IN), including yourself:

| NAME: | AGE: | RELATIONSHIP TO YOU: | RESIDING IN: |
|-------|-------|----------------------|--------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Physician: _____ Phone: _____

Employer: _____ Occupation: _____

Work Phone: _____ Cell Phone: _____ SSN: _____ - _____ - _____

If we need to leave you a confidential message (i.e., related to your treatment here), where can we do this (please initial any that apply)? Home _____ Cell _____ Work _____

Emergency contact person: _____ Phone number: _____

II. CHILDHOOD EXPERIENCE

Please give a brief description of your childhood (e.g., was it pleasant, difficult, etc., and why)

Please describe the quality of your relationship with your father (or step-father): _____

Please describe the quality of your relationship with your mother (or step-mother): _____

Please describe the quality of your relationship with siblings: _____

Please describe the quality of your relationships with friends/co-workers: _____

Please describe any serious illnesses/injuries (e.g., requiring hospitalization) you have experienced, either as a child *or* adult: _____

Please provide information concerning any abuse or neglect you have experienced, either as a child *or* adult: _____

III. FAMILY & SOCIAL NETWORK

Please circle all that currently apply to you:

Single.....Married.....Living Together.....Seriously Dating.....Casually Dating.....Divorced....Widowed

Please provide information concerning any current significant relationship circled above (e.g., name or significant other, duration and satisfaction with relationship, etc.):

Please list any other significant relationships from the past, noting the duration of each relationship and why it ended:

If you have children, please list them below:

Table with 4 columns: NAME, AGE, RELATIONSHIP TO CLIENT, RESIDING IN: and 8 rows of blank lines for data entry.

What are your principal sources of social support? (e.g., friends, church, participation in clubs or groups, etc.)

To whom are you most likely to turn to in times of need?

IV. EDUCATIONAL/OCCUPATIONAL HISTORY

Please briefly detail your educational accomplishments: _____

What (if any) future plans or desires do you have? _____

Please complete the following concerning your work history (3 most recent [including present] jobs):

EMPLOYER---JOB DESCRIPTION---DATES OF EMPLOYMENT---REASON FOR LEAVING

| EMPLOYER | JOB DESCRIPTION | From | To | REASON FOR LEAVING |
|----------|-----------------|-------|-------|--------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Place an 'X' on the following scale to show the degree of satisfaction you feel with your present job:

Very Unsatisfied _____ Very Satisfied

Please briefly describe your vocational (i.e., work-related) aspirations: _____

V. PHYSICAL HEALTH

Please summarize your current physical health: _____

Please list any current prescription medication you take, the dosage, when you began taking it, who prescribed it, and the reason for taking it.

| <u>Medicine</u> | <u>Dosage/Day</u> | <u>Began</u> | <u>Prescribing physician</u> | <u>Reason for medicine</u> |
|-----------------|-------------------|--------------|------------------------------|----------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

What is your opinion about medication that is used to improve a person's psychological functioning?

VI. PRESENTING PROBLEM, HISTORY OF PROBLEM(S)

What happened to lead you to seek therapy at this particular time? _____

Please describe what you have done to try to solve your problems, specifying what has worked and what hasn't worked: _____

Please list any troublesome symptoms (in behavior, mood, or physical functioning) you are currently experiencing: _____

Please provide details of any family (e.g., parents, siblings, or extended family) history of problems similar to those you are experiencing. Please also note a family history of *any* mental health problems (e.g., depression, anxiety, hyperactivity, alcoholism, suicide, etc.) -- whether treated or not:

If you have ever taken prescription medication *for the purpose of improving mood or behavior*, please indicate when and for how long, the name of the medication, and the reason for taking it:

If you have had any previous psychiatric treatment, please indicate (use back page if necessary):

- Where the therapy took place _____
- Who the therapist was _____
- The approximate dates spanning the therapy – From _____ To _____
- The approximate number of therapy sessions _____
- The reason for seeking help _____

Did you have a positive experience? If no, why not? _____

What did you find *most* helpful? _____

What did you find *least* helpful? _____

VII. WORKING TOWARDS A SOLUTION

Please list several specific problem areas that you would like to see resolved as a result of therapy.

Problem area #1: _____

On a scale of 0 to 10, I would rate this problem (make an 'X' on the line):

0-----10
Not a problem A major problem

This will no longer be a problem when (i.e., the things that will be different will be)

- 1. _____
- 2. _____

Problem area #2: _____

On a scale of 0 to 10, I would rate this problem (make an 'X' on the line):

0-----10
Not a problem A major problem

This will no longer be a problem when (i.e., the things that will be different will be)

- 1. _____
- 2. _____

Problem area #3: _____

On a scale of 0 to 10, I would rate this problem (make an 'X' on the line):

0-----10
Not a problem A major problem

This will no longer be a problem when (i.e., the things that will be different will be)

- 1. _____
- 2. _____

VII. CLINICAL ASSESSMENT
(To be completed by therapist at initial session)

I. MENTAL STATUS: oriented x 4 (person, place, time, situation) -Yes/No

Comment (as needed): _____

II. SAFETY CONCERNS: patient risk

Table with 5 columns: Risk Category, None, Current, Recent, Past. Rows include HOMICIDE, SUICIDE, and ELOPEMENT RISK.

If there is any response other than 'None' in the above three areas, please indicate severity (mild, moderate, severe) and presence of Ideation, Method, Plan, and Intent. If necessary, proceed with more detailed assessments and interventions: _____

III. SUBSTANCE USE HISTORY

Table with 5 columns: Substance, None, Current, Recent, Past. Rows include ALCOHOL, NICOTINE, PRESCRIPTION DRUG ABUSE, RECREATIONAL DRUGS, and CAFFEINE.

- 1. Does the use of any above substance meet DSM-IV criteria for abuse?
2. Does the use of any above substance meet DSM-IV criteria for dependence?
3. Substance abuse/dependence treatment history:

Comments (as needed): _____

IV. HISTORY OF ALLERGIES..... None Current Recent Past
HISTORY OF ADVERSE REACTION TO MEDS None Current Recent Past

Comments (as needed): _____

Therapist signature: _____