MARRIAGE ***& F***AMILY ***R***ELATIONS ***C***ENTER

A SUBSIDARY OF *PSYCHOLOGICAL ASSESSMENT& TREATMENT SPECIALISTS, INC.*

BIOGRAPHICAL DATA FORM © 1998

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 *MFRC* by: _____

This form was completed by: _____

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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:

NAME	AGE	RELATIONSHIP TO CLIENT	RESIDING IN:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

_____	_____	From	To	_____
_____	_____	From	To	_____
_____	_____	From	To	_____

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.

Medicine	Dosage/Day	Began	Prescribing physician	Reason for medicine

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

A. HOMOCIDE……	None	Current	Recent	Past
B. SUICIDE……..	None	Current	Recent	Past
C. ELOPEMENT RISK……	None	Current	Recent	Past

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

A. ALCOHOL…….....	None	Current	Recent	Past
B. NICOTINE……	None	Current	Recent	Past
C. PRESCRIPTION DRUG ABUSE……	None	Current	Recent	Past
D. RECREATIONAL DRUGS…….	None	Current	Recent	Past
E. CAFFEINE……	None	Current	Recent	Past

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: _____