Conditt

— Psychological Service

Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the Office Policy form. 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.

CLIENT INFORMATION

Client's Name: ____________________________ **M/F** (circle one) **DATE:**_____/_____/_______

Mother's Name:__________________________ **Father's Name**___________________________

Client's Date of Birth: _______/_______/_________

Address: ___________________________________**City:**___________________**Zip:** __________

TELEPHONE (circle where a message can be left)

Mother: __________________**Father:** __________________ **Client:** _____________________

Email: ____

We provide confirmation of all appointments 24 hours in advance.
The No-Show or late cancel charge is the full charge for the session.

EMERGENCY CONTACT PERSON

Name______________________________ **Phone** _____________________

Relationship to client____

Name of School: ____Grade _________________

How did you hear about us? ____

PRESENTING PROBLEM/WHY YOU CAME IN FOR SERVICES

What difficulties is your child having?

____

____

When did they start?

____

What areas of life do they affect (school, family, community)?

____

____

How would you estimate the severity of the above problem?

Mild _____ Moderate _____ Severe _____ Very severe _____

What would you like to accomplish in therapy? ____

____

MEDICAL DOCTOR

Physician's Name ____

Facility Location ____

Phone Number ____

**If you would like us to coordinate services with this doctor, please sign the release form.

**If you need information released to more than one professional, ask for another release form.

HISTORY OF MEDICAL CARE

Please list any major medical problems including but not limited to: surgeries/procedures, illnesses, accidents that may be relevant to the present need for therapy.

____

____

____

Medication/Supplement	Dosage	Condition

FAMILY HISTORY

Describe any presence of the following from any members of your family

Suicide____

Depression____

Abuse ____

Alcoholism ____

Admittance to Mental Institution ____

Describe any suicide attempts or violent behaviors exhibited by you/your child. Include age, persons involved and surrounding circumstances.

____

____

Parents/Step-Parents (if applicable) of Client

Include their name, age/year of death, cause of death, brief statement about the relationship.

Mother____

Father ____

Step-Mother ____

Step-Father ____

Siblings of clients, including half/step-siblings

Provide name and age of siblings and brief statement about the relationship with them:

1.____

2.____

3.____

4.____

5.____

Friendships, Community and Spirituality – Describe the quality, frequency, activities, and social life of your child's relationships outside of the home.

____

____

____

PREVIOUS THERAPY

If you have received psychotherapy in the past, specify the time from beginning to end of therapy and number of sessions, and initial reason(s) for need of therapy

Therapist Name	Dates	Reason	Helpful?