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Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. 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.

DATE: _____ REFERRED BY: _____

NAME: _____ MALE / FEMALE: _____

DATE OF BIRTH: _____ AGE: _____

PRIMARY ADDRESS:

TELEPHONE: Home: _____ Cell: _____ Work: _____

Email address: _____

HOW DO YOU PREFER TO BE CONTACTED? Cell phone Home phone Work/office Email

CAN MESSAGES BE LEFT AT YOUR PREFERRED PHONE NUMBER or EMAIL? YES NO

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

EMPLOYER/OCCUPATION (former, if retired or unemployed):

HIGHEST GRADE /DEGREE COMPLETED: _____ TYPE OF DEGREE: _____

REASON FOR VISIT:

Estimate the severity of above problem: Mild Moderate Severe Very severe

CURRENT STATUS: Single Married Separated Divorced Living with someone
Name: _____ # Years together: _____

PRESENT SPOUSE/PARTNER'S: Education: _____ Occupation: _____

DESCRIBE YOUR RELATIONSHIP WITH PARTNER (i.e., friendly, distant, physically/emotionally abusive, loving, hostile.):

CHILDREN/STEP-CHILDREN (names/ ages & brief statement on your relationship with the person.)

1. _____
2. _____
3. _____

PARENTS/STEP-PARENTS (Name/age, or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship.):

Father: _____

Mother: _____

Stepparents: _____

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship.):

1. _____
2. _____
3. _____

MEDICAL DOCTOR (S) (name/phone): _____

PAST/PRESENT MEDICAL CARE (major medical problems, accidents, head injuries, illness, etc.):

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

PAST/PRESENT COUNSELING (specify: name of therapist, estimated no. of sessions, initial reason for therapy, was it helpful?):

1. _____

2. _____

(USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED).

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

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):

SUICIDE ATTEMPT(S) or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc.)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc.):

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

DESCRIBE YOUR CHILDHOOD, IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____.
Describe how it affected you at the time

ESTIMATE HOW MANY HOURS PER DAY YOU SPEND ONLINE

Facebook/Instagram/Twitter _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____
Work/School: _____ Other: _____

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY? OR COULD IT USE IMPROVEMENT? Please explain:

What gives you the most joy or pleasure in your life?

What are your main worries and fears?

What are your most important goals?