BIOGRAPHICAL INFORMATION - INTAKE FORM

Janice DeCovnick, Ph.D.

Licensed Clinical Psychologist - PSY7973
Licensed Marriage, Family, And Child Counselor - MFT17769

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.

NAME: _____ MALE/FEMALE: ____ DATE :_____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: H : _____ W: _____ Cell:_____ FAX: _____

Best number to call to leave a discreet message during work hours_____ Best number to leave a confidential message_____

INSURANCE INFORMATION: Name of Insurance _____ Group #_____
Name of Insured_____ SS# or Insurance Member ID#_____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON AND PHONE NO. TO CALL IN EMERGENCY: _____ _____

REFERRAL SOURCE: _____

OCCUPATION (former. if retired): _____

PRESENTING PROBLEM (What brings you to treatment? Be as specific as you can: when did it start, how does it affect you…):

_____

_____

_____

___

Estimate the severity of the above problem: Mild__, Moderate__, Severe ___, Very severe __

CURRENT: Marital status: __ Live with someone: ___ Name: _____ Years: __

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

_____

_____

_____

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_____

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person) (lives with?)

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

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

Father:_____

_____

_____

Mother:_____

_____

_____

Step-parents_____

_____

_____

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

1._____

2._____

3._____

4._____

5._____

MEDICAL DOCTOR/S (PCP, psychiatrist, specialists for major medical problems – name/address/phone):_____

_____

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PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

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_____

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Specify all <u>MEDICATION</u> you are presently taking, dosage, dates of initial prescriptions, name of prescribing professional and for what condition. <u>PRINT clearly:</u>_____

_____

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Allergies/adverse reactions to treatment:_____

_____

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COORDINATION OF CARE:_____I prefer you to coordinate care with my PCP;_____I prefer you to coordinate care with my major medical problem specialist(s) (specify which one(s))_____; _____I prefer to coordinate my care with my doctors myself; I will contact them directly regarding relevant psychological care issues.

PAST/PRESENT PROBLEMS WITH FOOD/APPETITE (Please describe nature of problem, date and duration of problem, types and dates of

treatment):_____

PAST/PRESENT PROBLEMS WITH SLEEP (Please describe nature of problem, date and duration of problem, types and dates of treatment):_____

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PAST/PRESENT PROBLEMS WITH SEXUAL FUNCTIONING (Please describe nature of problem, date and duration of problem, types and dates of treatment):_____

_____

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PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (substances used – including cigarettes, caffeine, alcohol, illicit drugs, prescription and over-the-counter drugs, age started, frequency of use, how long, legal, family, occupation, physical problems due to substance abuse, AA, NA, types and dates of treatment):

SEXUAL ABUSE HISTORY (victim, perpetrator, ages, frequency, any legal proceedings, types and dates of treatment):_____

_____

_____

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

_____

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_____

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FAMILY MEDICAL HISTORY (Describe any <u>illness</u> that runs in the family: cancer, epilepsy, etc)**:**

_____

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FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

_____

_____

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended)**:**

1. _____

_____

_____

2. _____

_____

_____

3*. USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS*

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent) (for a child or adolescent, please give a developmental history):

_____

_____

__

_____

_

_____

_

IF PARENTS DIVORCED: Your (or your child's) age at the time: _____, Describe how it affected you (for a child, you & your child) at the time. Describe custody/visitation arrangements:

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

What gives you most joy or pleasure in your life: _____

What are your main worries and fears: _____

What are your most important hopes or dreams: _____

What are your strengths:_____

Please add on this side and other side of the page or on a separate page any other information you would like me to know about you and your situation.

_____

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