

BIOGRAPHICAL INFORMATION AND INTAKE FORM

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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 Disclosure Statement 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: _____ Cell: _____ W/Off: _____ FAX: _____
FOR ROUTINE MESSAGES: Phone # _____ E-mail: _____
FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone # _____ E-mail: _____
HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____
NAME & PHONE NO. TO CALL IN EMERGENCY: _____
REFERRAL SOURCE: _____
OCCUPATION (former. if retired): _____
PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you...): _____

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

CURRENT: Marital status: _____ Live with someone: ____ Name: _____ Years: ____

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

PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____
CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. _____
2. _____
3. _____
4. _____

5. _____

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 (name /phone): _____

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

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

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

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

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

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):

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

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

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): _____

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

What are your main worries and fears?

What are your most important hopes or dreams? _____

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