Biographical Info / Intake Form - Adult

Nancy Kelley Franke, MA, LPC, ATR

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 wish 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____
Address____
E-mail address____
Phone Numbers: (h)_______________(w)_________________(c)__________________
Should I need to reach you, which number would you like me to call?________________
Can I leave a message?________
If not, how can I reach you while protecting confidentiality?________________________
Emergency contact number____
Date of birth_____________Age____________Place of Birth_______________________
Gender Identity __________Sexual Orientation ___________Ethnic Identity _________
Referral Source____
Can I thank the person who referred you?_________

Occupational History

Current Occupation______________________________
Employer______________________________________
Past Occupations____
Ideal/Dream Occupation(s)____
Highest Grade/Degree_________________________Type of Degree________________

Family History

Spouse, partner an/or significant other____________________________Age_________
Occupation____________________________________
Your marital status ______________________________
Marriage/divorce dates____
Children/grand/step (names/ages & brief statement on your relationship with the person)
1.____
2.____
3.____
4.____
5.____
Others in household including
pets____
Parents/Step-parent (names/ages & brief statement on your relationship with the person)
Father:____
Mother:____

Stepparents:____

Siblings (names/ages & brief statement on your relationship with the person)
1.____
2.____
3.____
4.____
5.____
Deceased Family Members or significant others and dates (including pets):
____
____
Is there a family history of alcoholism, mental illness or violence?
(including suicide, depression, hospitalizations in mental institutions, abuse, etc.):
____
____

Medical/Psychological History
Medical doctors (name /phone): ____
Any past/present medical care that would be helpful for me to know about? (major medical problems, surgeries, accidents, falls, illness):
____
____
____
Do you have any allergies? _______What types?________________________________
Are you currently or have you ever been on Medication? ________
If yes, please list the medication(s) and the reason?
____
____
Number of pregnancies & dates____
Childbirth Experience(s) and dates____
____
How often do you drink Alcohol?_______Smoke__________Rec Drugs________Casual Sex_______Gambling______Other addictive behaviors(please specify)______________
Have you ever been treated for substance abuse or other addictive behaviors?_________
Where were you in treatment________________Dates____________Does your recovery feel solid?___________________
Do you think you have an untreated addiction?_____ If yes, what substance(s) or behaviors?____
Have you ever considered or attempted suicide? ______Did you have a plan? _________
Do you feel suicidal now?________
Have you ever been hospitalized for depression or other emotional distress?___________
(if yes, please describe reason for hospitalization and outcome)_____________________
____
____
____

Were there any other traumatic events or accidents in your life? ____________________
____
____

Current Symptoms

Please check any of the following which have been problems in the last few months:

Body:	**Emotions:**	**Mental:**
___weight loss/gain	___anger	___making decisions
___headaches	___anxiety	___suicidal thoughts
___appetite loss/gain	___depression	___invasive thoughts
___fatigue	___shyness	___divorce/separation
___increased energy	___nervousness	___marital problems
___stomach trouble	___grieving/sadness	___finance problems
___dizziness	___unhappiness	___children
___relaxation	___inferior feelings	___work problems
___bowel/urinary problems	___temper control	___concentration
___genital problems	___fears	___legal problems
___insomnia	___nightmares	___memory
___tension/stress reactions	___loneliness	___education
___Other, explain__________	___Other, explain__________	___Other, explain__________
______________________	______________________	______________________

Have you been in psychotherapy before? ___________
What was beneficial? ____
What was not helpful?____
Please state briefly your reasons for seeking therapy at this time. List your specific concerns.
____
____
____
What are your goals for therapy?
____
____
____
What is your experience with art materials and how do you feel about making art?
____
____

Religious/Spiritual History

What was your religious upbringing and what is your spiritual orientation now?
____
____
Any meditation practice or experience? If so, what and how often? _________________
____
Is this a practice you would like to explore?_______What kind?____________________

What would you say is your fundamental belief about your religious or spiritual orientation?____
____
How important is this aspect in your life?____________________________________

<u>Life Skills and Self Care</u>

Hobbies/Interests____
_
Do you exercise?_____ What kind?_________________________How often________
What do you like to do for self care?____
Who (person or groups) is your support system_________________________________
____
What brings you joy or pleasure in your life___________________________________
What are your hopes and dreams for yourself__________________________________
____
If you could achieve your highest dream, what would that be?_____________________
____

Please use space below or the back to add any other information you would like me to know about you and your situation. Thank you for your time.