AFFILIATES IN CLINICAL SERVICES, PC
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ADULT BIOGRAPHICAL FORM

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank. *This information is strictly confidential*.

Personal History

1) Name (first, middle, last): _____
2) Age: ____
3) Gender: ☐M ☐F
4) Date of Birth: _____
5) Years education: _____
6) Occupation_____
7) Present Marital Status:
   ☐ Single ☐ Divorced ☐ Committed relationship
   ☐ Separated ☐ Living together ☐ Domestic partnership
   ☐ Married ☐ Widowed ☐ Other (specify) _____
8) If married/committed/partnership, are you living with your spouse/partner? Yes ☐ No ☐
9) If married/committed/partnership, years together? _____ Years married? _____
10) Any children? Yes ☐ No ☐ If yes, Gender/Age(s) _____

Psychological/Psychiatric History

11) What is (are) your main reason(s) for this visit? _____
    _____
    _____
12) How long has this problem persisted, from 11)? _____
    _____
13) Are you receiving psychological/psychiatric services at present? Yes ☐ No ☐
    If Yes, please briefly describe treatment and current response: _____
    _____
14) Have you received psychological/psychiatric services in the past? Yes ☐ No ☐
    If Yes, please briefly describe treatment and response: _____
    _____
15) Under what conditions do your problems usually get worse? _____
    _____
16) How did you hear about this clinic, or who referred you? _____
    _____

Medical History

17) Primary Care Physician (PCP):
    Provider's name: _____
    Address/Phone Number: _____
18) List present physical issues: (e.g., high blood pressure, headaches, dizziness, etc.)
    _____
19) On average how many hours of sleep do you get daily? _____
20) Do you have trouble falling asleep at night? Yes ☐ No ☐ If Yes, describe _____
    _____
21) Weight change in past year? Yes ☐ No ☐, pounds ___, + or -, on purpose? Yes ☐ No ☐

22) Current medications/dosages, including over the counter, are you taking?

Medication	Prescribed by	Dose	Purpose

Religious Concerns

23) What is your present religious affiliation? _____
24) How important is religious commitment to you? _____

Family History

25) Mother's age:_____ If deceased, how old were you when she died? _____
26) Father's age:_____ If deceased, how old were you when he died? _____
27) If your parents are separated or divorced, how old were you then? _____
28) Number of brother(s) _____ Their ages ____ _____ _____ _____ _____ _____ _____
29) Number of sister(s) _____ Their ages ____ _____ _____ _____ _____ _____ _____
30) I was child number _____ in a family of _____ children.
31) Were you adopted or raised with parents other than your natural parents? Yes☐ No ☐
32) Is there a history of, or recent occurrence(s) of, abuse? Yes ☐ No ☐
If Yes, which type(s) of abuse? Verbal _____ Physical ____ Sexual _____

Comments:

_____
_____

Thoughts and Behaviors

33) Please check how often the following thoughts occur to you:

a)	Life is hopeless.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
b)	I am lonely.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
c)	No one cares about me.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
d)	I am a failure.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
e)	Most people don't like me.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
f)	I want to die.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
g)	I want to hurt someone.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
h)	I am so stupid.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
i)	I am going crazy.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
j)	I can't concentrate.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
k)	I am so depressed.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
l)	God is disappointed in me.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
m)	I can't be forgiven.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
n)	Why am I so different?	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
o)	I can't do anything right.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
p)	People hear my thoughts.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
q)	I have no emotions.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
r)	Someone is watching me.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
s)	I hear voices in my head.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently
t)	I am out of control.	☐ Never	☐ Rarely	☐ Sometimes	☐ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____
_____
_____

Symptoms

34) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

☐ aggression	☐ fatigue	☐ prescription drug abuse
☐ alcohol dependence	☐ hallucinations	☐ recurring thoughts
☐ anger	☐ headaches	☐ sexual difficulties
☐ antisocial behavior	☐ heart palpitations	☐ sick often
☐ anxiety	☐ high blood pressure	☐ sleeping problems
☐ avoiding people	☐ hopelessness	☐ speech problems
☐ caffeine use	☐ impulsivity	☐ suicidal thoughts
☐ chest pain	☐ irritability	☐ thoughts disorganized
☐ depression	☐ judgment errors	☐ trembling
☐ disorientation	☐ loneliness	☐ withdrawing
☐ distractibility	☐ memory impairment	☐ worrying
☐ dizziness	☐ mood shifts	☐ other (specify)
☐ drug dependence	☐ nicotine/tobacco use	_____
☐ eating disorder	☐ panic attacks	_____
☐ elevated mood	☐ phobias/fears	_____

35) Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____
_____
_____

36) List your five greatest strengths:

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

37) List your five greatest weaknesses:

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

38) List your main social difficulties: _____
_____

39) List your main love and sex difficulties: _____
_____

40) List your main difficulties at school or work: _____
_____

41) List your main difficulties at home: _____
_____

42) List your behaviors that you would like to change: _____
_____

43) Additional information you believe would be helpful: _____
_____

PLEASE COMPLETE THIS AND OTHER REQUESTED ASSESSMENT MATERIALS PRIOR TO YOUR FIRST APPOINTMENT.