GRATEFUL HEART
HOLISTIC THERAPY CENTER

Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. 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:_____Gender Identification:_____Date:_____

Date of Birth: _____Place of Birth: _____

Address: _____City/State_____Zip_____

Telephone Contact: Home #_____Cell #_____

Work/Office #_____X_____Fax #_____

Routine Messages: Phone #_____

Confidential Messages: Phone #_____

Email: Email_____ @ _____

Person and Phone No. To Contact in Emergency: _____

Referral Source: _____

Employment/occupation (former, if retired/unemployed): _____

Why are you seeking therapy? (Please be as specific as possible, using back of page if needed)_____

_____

_____

_____

_____

RELATIONSHIP STATUS [ ] Single: How long:_____

[ ] Cohabitating: Name_____ Years_____

[ ] Partnered: Name_____ Years_____

[ ] Married: Name _____ Years_____

[ ] Separated: Name _____ Years_____

[ ] Divorced: Name _____ Years_____

[ ] Widowed: Name _____ Years_____

Sexual Orientation/s: _____

PAST/PRESENT MARRIAGE/S or PARTNERSHIPS: Please share anything about the qualities of your close relationships._____

_____

_____

_____

CHILDREN/STEP/GRAND: Names, ages and brief statement regarding your relationship with the person

1._____

2. _____

3. _____

PARENTS/STEPPARENTS: Names, ages and brief statement regarding your relationship with the person, including whether they are still living.

Parent 1:_____

_____

_____

Parent 2: _____

_____

_____

Step-parents:

SIBLINGS: Names, ages and brief statement regarding your relationship with the person, including whether they are still living.

1.

2.

3.

MEDICAL DOCTOR (S): Name: Phone

Name: Phone

PAST/PRESENT MEDICAL CARE: Please list any major surgeries, accidents and/or illnesses

PLEASE SPECIFIY IF YOU ARE TAKING ANY MEDICATIONS:

Medication	Purpose	Dosage	Frequency

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

HISTORY OF SUICIDALITY and/or ATTEMPTS: Please describe the timing and circumstances

FAMILY MEDICAL HISTORY: Describe any significant medical history for your family

FRIENDSHIPS AND COMMUNITY:

PAST/PRESENT PSYCHOTHERAPY: Specify name of therapist, plus dates of service and type of therapy

Therapist	Dates	Type

DESCRIBE YOUR CHILDHOOD, IN GENERAL: Relationships with parents, siblings and others, school experience, number of home relocations, major experiences of loss, trauma or abuse

IF PARENTS DIVORCED: Your age at the time: _____Describe how it affected you at the time

ARE YOUR COMFORTABLE WITH YOUR ONLINE/INTERNET USE? Please explain:

PLEASE DESCRIBE ANY FAMILY HISTORY OF ADDICTION, TRAUMA, ILLNESS or PSYCHOLOGICAL CHALLENGES

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 below, 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.