DISCOVERY COUNSELING AND ASSESSMENT CENTER

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4006 East Hwy 34 Sharpsburg, GA 30277
420 Thomaston St. Zebulon, GA 30295
Phone: (404) 960-1282 Fax: (855) 817-2428 Email: info@discoverycounselingllc.com

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 Office Policy form and the HIPAA Notice of Privacy Practices. 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.

CLIENT NAME: _____ MALE/FEMALE: _____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: Home: _____ Cell: _____ Other: _____

***IF MINOR, PARENT/GUARDIAN NAME:_____ DATE OF BIRTH: _____**

***RELATIONSHIP TO CLIENT (mark one): _____Parent _____Other (please specify):_____**

***PARENT/GUARDIAN CELL PHONE: _____**

***PARENT/GUARDIAN ADDRESS:_____**

FOR ROUTINE MESSAGES: Phone #_____ E-mail: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ E-mail: _____

CURRENT: Marital status: _____Live with someone: _____ Name: _____Years: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & 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 (circle): Mild-Moderate-Severe-Very severe

MEDICAL DOCTOR/S (name /phone): _____

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

_____

_____

SPECIFY <u>MEDICATION</u> you are presently taking and for what. <u>PRINT</u> 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 <u>illness</u> that runs in the family: cancer, epilepsy, etc.)**:**

_____

_____

_____

SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

PAST/PRESENT Mental Health Treatment: (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Individual/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?

_____

_____

_____

_____