David S. Terry, Ph. D

Licensed Psychologist | PSY22263

Biographical Information Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. You may leave any questions blank that you feel do not apply to you or that you prefer not to answer. All information is confidential as outlined in the Office Policy Form and the HIPAA Notice of Privacy Practices.

Personal History

Name: ______________________________

Address: ______________________________

Date of Birth: ____________ Age: ______ Place of Birth: ______________

Gender: ______________ Ethnicity/Racial Identity: ______________

Level of Education/Degree: ______________ Occupation: ______________

Contact Information:

Home: ______________ Is it OK to leave a confidential message? ☐ Yes ☐ No

Cell: ______________ Is it OK to leave a confidential message? ☐ Yes ☐ No

Work: ______________ Is it OK to leave a confidential message? ☐ Yes ☐ No

Fax: ______________

Emergency Contact Information (Name/Relationship/Phone):

____

Counseling Goals & History

What are your main reasons for coming to counseling?

____

____

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____

Have you received counseling in the past? ☐ Yes ☐ No

If yes, please describe:

____

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Current Symptoms

Are you currently experiencing thoughts of hurting yourself? ☐Yes ☐ No
Are you currently experiencing thoughts of hurting someone else? ☐Yes ☐ No

Please check any symptoms that might be bothering you:

☐ aggression
☐ alcohol
☐ anger
☐ anxiety
☐ avoiding people
☐ attention
☐ confusion
☐ depressed mood
☐ difficulties making decisions
☐ distractibility
☐ emptiness
☐ eating disorder
☐ failure
☐ fatigue
☐ fears
☐ grief
☐ guilt
☐ headaches
☐ health problems
☐ hopelessness
☐ impulsiveness
☐ inferiority feelings
☐ irritability
☐ judgment problems
☐ loneliness
☐ low motivation
☐ memory problems
☐ mood swings
☐ panic attacks
☐ poor concentration
☐ poor self-esteem
☐ procrastination
☐ self-harming behaviors
☐ sexual problems
☐ weight problems

Please check any current stressors you are experiencing:

☐ abuse
☐ childhood problems
☐ custody problems
☐ divorce/separation
☐ financial problems
☐ gambling
☐ interpersonal conflicts
☐ legal problems
☐ poor social support
☐ parenting problems
☐ relationship problems
☐ school problems
☐ work problems

Is there any additional information that you would like to share that would be helpful for our work together?____

Social History

Marital/ Relationship Status (Check all that apply):
☐ Single☐Dating ☐Partnered ☐ Married ☐Separated☐Divorced ☐ Widowed

Please complete the following regarding your family (as applicable):

Name	Do they live in household?	Age	Occupation	Quality of Relationship
Spouse:				
Children:				
Parents:				
Siblings:				

Please list any family history of mental health issues and/or drug and alcohol issues:____

Medical History

Medical Provider (Name/Phone): ______________________________

Do you exercise regularly? Please describe: ______________________________

List any major illnesses and/or operations that you have had: ______________________________

List any physical concerns that you are presently having (e.g. high blood pressure, headaches, dizziness, etc.): ______________________________

Approximate date of most recent physical exam: __________

Please list any medications, vitamins and/or supplements you are currently taking:

____

Are you having any difficulties with your sleeping patterns? ☐ Yes ☐ No

If yes, please describe: ______________________________

Please complete the following substance assessment:

Substance	Current Use (last 6 months)			Past Use		
	Yes	No	Amount/ Frequency	Yes	No	Amount/ Frequency
Caffeine						
Alcohol						
Cigarettes						
Tobacco						
Marijuana						
Other:						