Crossroads Counseling, PLLC
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Biographical Information Form - Adult

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.

Personal History

Name: _____ Age: _____ Gender: _____ M _____F

Years of Education: _____ Occupation: _____ Today's Date: _____ _____

Home Phone #: (____)_____ Work phone #: (____)_____ Cell Phone #: (____)_____

Present Marital Status:

_____ never married _____ married now after first time _____widowed and not remarried

_____ engaged to be married _____ separated _____ other (specify) _____

_____ married now for first time _____ divorced and not remarried _____

Counseling History

Have you received counseling in the past? _____ Yes _____ No If Yes, please briefly describe: _____

_____

_____

Main reason for this visit:: _____

Additional reasons for visit: _____

_____

How long has this problem persisted? _____

_____

What medications (and dosages) are you taking at the present, and for what purpose?

Medication:	Dosage:	Purpose:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your present religious affiliation?

_____ Catholic _____ Jewish _____ Protestant (specify denomination if any) _____

_____ None, but I believe in God _____ Atheist or agnostic _____ Other (please specify) _____

Do you desire to have your religious beliefs and values incorporated into the counseling process? _____Yes _____No _____Not sure

(If Yes, please explain): _____

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

Life is hopeless.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
No one cares about me.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I am a failure.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Most people don't like me.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I want to die.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I want to hurt someone.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I am so stupid.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I am going crazy.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
God is disappointed in me.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I can't be forgiven.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Why am I so different?	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I have no emotions.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
Someone is watching me.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I hear voices in my head.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently
I am out of control.	_____ Never	_____ Rarely	_____ Sometimes	_____ Frequently

Symptoms

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

____ aggression	____ distractibility	____ impulsivity	____ recurring thoughts
____ alcohol dependence	____ dizziness	____ irritability	____ sexual difficulties
____ anger	____ drug dependence	____ judgment errors	____ sick often
____ anxiety	____ eating disorder	____ memory impairment	____ sleeping problems
____ avoiding people	____ elevated mood	____ mood shifts	____ thoughts disorganized
____ chest pain	____ fatigue	____ panic attacks	____ trembling
____ depression	____ hallucinations	____ phobias/fears	____ worrying
____ disorientation	____ heart palpitations	____ poor concentration	____ other_____

Briefly discuss how the above symptoms impair your ability to function effectively: _____

_____

_____

_____

Any additional information that would assist us in understanding your concerns or problems: _____

_____

_____

_____

What are your goals for therapy? _____

_____

_____