SOPHIA CENTER, INC.
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 or you are not comfortable answering them, leave them blank.

PERSONAL HISTORY

Client ID#:_____ (Office use only) Today's Date_____ E-Mail_____

Name _____ Age_____Gender ☐ M ☐ F

Address _____City_____State_____Zip _____

Date of Birth:_____Years of Education_____Occupation_____

Homes Phone:_____Business Phone:_____Cell Phone:_____

Ethnic Origin: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Other _____

Present Marital Status:

- ☐ Never Married
- ☐ Married now for the first time
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living with spouse
  # of years married_____
- ☐ Living with significant other
- ☐ Divorced and Remarried

Family Information. Please list spouse and/or significant other and children.

Name	Age	Relationship to patient	Highest Grade Grade of School Completed (or current grade)	Work/ Vocation
1.				
2.				
3.				
4.				
5.				
6.				
7.				

COUNSELING HISTORY

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

Name of provider: _____
Address _____
Telephone _____

Are you receiving counseling services at present?: Yes ☐ No ☐
If YES, please briefly describe:
_____
_____

Name of provider: _____
Address _____
Telephone _____

What is (are) your main reason(s) for this visit?:
_____
_____
_____

How long has this problem persisted?:
_____

Under what conditions do your problems usually get worse?:
_____

Under what conditions are your problems usually improved?:_____

How did you hear about this clinic, or who referred you?:
_____

MEDICAL HISTORY

Name of your primary physician:
_____

List any major illnesses and/or surgeries you have had:
_____
_____

List any physical concerns you have had or are having (e.g., high blood pressure, headaches, dizziness, etc.):
_____
_____

When was your most recent physician visit?: _____

Are you allergic to any medication(s)? _____Yes _____No

If yes, please identify the medication(s):
_____
_____
_____
_____
_____

Are you allergic to other types of allergens such as dust, mold, cats, etc. If so, please identify.

_____

On average how many hours of sleep do you get daily?: _____

Do you have trouble falling asleep at night?: No ☐ Yes ☐ If YES, please describe

_____

Have you gained/lost over ten pounds in the past year?: Yes ☐ No ☐ _____gained _____ lost

If YES, was the gain/loss on purpose?: ☐ Yes ☐ No

Describe your appetite (during the past week):
☐ poor appetite ☐ average appetite ☐large appetite

Do your use caffeine> If so, explain_____

Do you or have you ever smoked cigarettes? _____Yes _____No How long? _____

Is there **history** of substance abuse for alcohol or drugs? Yes ☐ No ☐

Is there **current** substance abuse for alcohol or drugs? Yes ☐ No ☐

Substance use/abuse (circle all that apply):

alcohol **marijuana** **cocaine** **heroin/opiates**

tranquilizers **hallucinogens, LSD** **PCP, "dust"** **"ecstasy"** **others:** _____

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

Medication	Dosage	Purpose

RELIGIOUS CONCERNS

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) _____

Please describe your religious or spiritual beliefs at this time.

_____

_____

SPOUSAL/SIGNIFICANT OTHER INFORMATION

Is there anything you would like to share regarding your spouse or significant other?

_____
_____

Briefly describe your relationship with your family of origin:

_____
_____

PERSONAL PSYCHIATRIC HISTORY

Have you ever been hospitalized? ☐ **Yes** ☐ **No**

If so, When_____ Where?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY PSYCHIATRIC HISTORY

Please indicate the presence in <u>biological</u> relatives of any psychiatric problem, such as depression, suicide, alcoholism, drug abuse, anxiety, panic attacks, manic-depressive (bipolar) illness, schizophrenia, mental retardation, autism, learning disability, hyperactivity, attention deficit disorder, childhood behavior problems, school or academic problems, narcolepsy, obsessive compulsive disorder, etc.

Y	N	N/A		**Please provide details about problem(s) here:**
☐	☐	☐		_____
☐	☐	☐	**Father:**	_____
☐	☐	☐	**Father's parents, brothers, sisters:**	_____
☐	☐	☐	**Mother:**	_____
☐	☐	☐	**Mother's parents, brothers, sisters:**	_____
☐	☐	☐	**Client's brothers and sisters:**	_____
☐	☐	☐	**Other biological relatives:**	_____
☐	☐	☐	**Any family history of suicide?**	_____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

Life is hopeless.	___Never	___Rarely	___Sometimes	___Frequently
I am lonely.	___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
I can't concentrate.	___Never	___Rarely	___Sometimes	___Frequently
I am so depressed.	___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 can't do anything right.	___Never	___Rarely	___Sometimes	___Frequently
People hear my thoughts.	___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

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

Check the behaviors and symptoms that occur to you more often than you would like them to take place. Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.).

_____ aggression_____
_____ alcohol dependence_____
_____ anger_____
_____ illegal behavior_____
_____ anxiety_____
_____ avoiding people_____
_____ chest pain_____
_____ depression_____
_____ disorientation_____
_____ distractibility_____

SYMPTOMS, continued

_____ dizziness
_____ drug dependence
_____ eating disorder
_____ elevated mood
_____ fatigue
_____ hallucinations
_____ heart palpitations
_____ high blood pressure
_____ hopelessness
_____ impulsivity
_____ irritability
_____ judgment errors
_____ loneliness
_____ memory impairment
_____ mood shifts
_____ panic attacks
_____ phobias/fears
_____ recurring thoughts
_____ sexual difficulties
_____ sick often
_____ sleeping problems
_____ speech problems
_____ suicidal thoughts
_____ suicidal attempts
_____ thoughts disorganized
_____ trembling
_____ withdrawing
_____ worrying
_____ other (specify)

List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

List your five greatest areas of concern:

1) _____
2) _____
3) _____
4) _____
5) _____

List behaviors that you would like to change:

_____
_____

List any social difficulties:

_____
_____

List any difficulties at school or work:

_____
_____

List any difficulties at home:

_____
_____

List main difficulties with the thought process, i.e., memory loss, forgetfulness, etc., if any:

_____
_____
_____

Additional information that you believe would be helpful_____
_____
_____
_____
_____
_____
_____
_____
_____

PEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT YOUR NEXT APPOINTMENT.