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

Date: _____ /____ /_____

Email: _____

Client's full name: _____

Nickname: _____

Address: _____

City, State, Zip: _____

Home Phone #: _____ Business Phone #: _____

Cell Phone #: _____

Date of Birth: _____ /____ /_____ ☐ Male ☐ Female

Years of Education: _____ Occupation: _____

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

Present Marital Status:

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

FAMILY INFORMATION

Please list the family members you live with.

Name	Age	Relationship to Patient	Highest Grade of School Completed (or current grade)	Work/Vocation

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.? ☐ Yes ☐ No

If so, please identify:

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

Do you have trouble falling asleep at night? ☐ Yes ☐ No

If YES, please describe:

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

_____ lbs. gained _____ lbs. 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 you use caffeine? ☐ Yes ☐ No

If so, please explain:

Have you ever smoked cigarettes? ☐ Yes ☐ No

If YES, how long? _____

Do you have a history of drug and/or alcohol abuse? ☐ Yes ☐ No

Do you currently have any issues with drug and/or alcohol use or abuse? ☐ Yes ☐ No

Substance use/abuse (check all that apply):

☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ Heroin/Opiates

☐ Tranquilizers ☐ Hallucinogens, LSD ☐ PCP, "dust" ☐ "Ecstasy"

☐ Others: _____

What medication(s) and dosages(s) are you taking at present and for what purpose(s)?

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 the family unit in which you were raised:

PERSONAL PSYCHIATRIC HISTORY

Have you ever been hospitalized? ☐ Yes ☐ No

If so, when and where?

FAMILY PSYCHIATRIC HISTORY

Please indicate if your biological relatives had or have any psychiatric problems, such as depression, suicide attempts or completion, alcoholism, drug abuse, anxiety, panic attacks, bipolar illness, schizophrenia, mental retardation, autism, learning disability, hyperactivity, attention deficit disorder, childhood behavior problems, school or academic problems, narcolepsy, obsessive compulsive disorder, etc.

Please provide details about problem(s) here:

◯Yes ◯No ◯N/A	Father _____
◯Yes ◯No ◯N/A	Father's parents, brothers, sisters _____
◯Yes ◯No ◯N/A	Mother _____
◯Yes ◯No ◯N/A	Mother's parents, brothers, sisters _____
◯Yes ◯No ◯N/A	Client's parents, brothers, sisters _____
◯Yes ◯No ◯N/A	Other biological relatives _____ _____
◯Yes ◯No ◯N/A	Any family history of suicide _____
◯Yes ◯No ◯N/A	Other illnesses _____

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., 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 AND BEHAVIORS

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 _____
- ☐ 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 _____

SYMPTOMS AND BEHAVIORS

- ☐ 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:

Please return this form and other assessment materials to Sophia Center at your earliest convenience. You may send forms via your TherapyNotes Portal, by email or deliver paper forms directly to Sophia Center.