SOPHIA CENTER

SOPHIA CENTER, INC.

BIOGRAPHICAL INFORMATION FORM – ADULT

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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

Today's Date: _____ /____ /_____ Email: _____

Who referred you?: _____

Name: _____ Preferred Name: _____

Ethnic Background: _____Cultural Preference: _____

Years of Education: _____ Occupation: _____

Home Phone #: _____ Business Phone #: _____

Cell Phone #: _____

Present Marital Status: _____

FAMILY INFORMATION

Please list the family members you live with.

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

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

_____

_____

Family Stressors (check any that apply):

- ☐ Family conflicts
- ☐ Parent/Child conflicts
- ☐ Partner conflicts
- ☐ Financial problems
- ☐ Recent deaths
- ☐ Physical illness (Medical problems)
- ☐ Frequent moves
- ☐ Drug/alcohol abuse by family member
- ☐ Trauma
- ☐ Other_____

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: _____

HISTORY OF CURRENT PROBLEMS

What brings you to counseling, (please list briefly):

How long has this problem persisted? _____

Please indicate any events occurring around that time that you believe may be related to the problems noted above:

Under what conditions do your problems usually get worse?

Under what conditions are your problems usually improved?

MEDICAL HISTORY

Primary Care Physician: _____

Address: _____

Telephone: _____

When was your most recent physician visit?: _____

Previous hospitalizations, surgery or major illnesses:

Dates of Treatment/Illness	Nature of Medical Problem	Outcome of Condition/Treatment

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

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? ☐ 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:

Do you or have you ever used nicotine? ☐ 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 (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? _____

Please describe your religious or spiritual beliefs at this time.

PERSONAL PSYCHIATRIC HISTORY

Have you received inpatient mental health treatment at facility? ☐ Yes ☐ No

If so, when? _____ Where? _____

Please describe:

FAMILY PSYCHIATRIC HISTORY

Please indicate the presence in biological relatives of any psychiatric problem, such as depression, suicide, alcoholism, drug abuse, anxiety, panic attacks, bipolar disorder, schizophrenia, intellectual disabilities, autism spectrum disorder, learning disability, attention deficit hyperactivity 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 brothers and sisters _____
◯Yes ◯No ◯N/A	Other biological relatives _____ _____
◯Yes ◯No ◯N/A	Any family history of suicide, if so, who: _____

Briefly describe your relationship with your current support system:

_____

_____

_____

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

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 _____
- ☐ Disorganized thoughts _____
- ☐ 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: