SOPHIA CENTER, INC.

BIOGRAPHICAL INFORMATION FORM – ADULT

5335 Silica Drive, Sylvania, OH 43560 Phone: 419.882.4529 Fax: 419.885.7612
sophiacenterinfo@sophia.center

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)

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____

TESTING 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 testing, (please list briefly):

1. ____
2. ____
3. ____

Have you had testing in the past and if yes, when? Please bring a copy of testing to first appointment. ____

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

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:

____

____

____

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 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:

____

____

____

____

____

____