# Biographical Questionnaire – CONFIDENTIAL

Client Initials & Date Completed: ______________

Mental Health Professional Initials: ______________

(More space is available on the last page to expand on any question)

Name(s): ____________________________________________

Date of Birth: ______________________ S.S.N.: ______________________

**Personal History:**

Single __________ Married __________ Divorced __________ No. of Marriages __________ Other__________

Dates of marriage(s) and divorce(s): ____________________________________________

Birthplace: ______________________ Relocation (when & where): ______________________

______________________

**Memories and emotional qualities of growing up years (i.e. parents' relationship, your relationship with them, with siblings, any family crisis, trauma):**

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________.

**Parents:** If living, age and health status: ____________________________________________

____________________________________________.

If deceased, when and cause: ____________________________________________

____________________________________________.

**Brothers and Sisters:** (how many and ages):____________________________________________

____________________________________________.

**Relational and/or marital history (significant relationships, when, length of time, emotional qualities of):** ______________________

____________________________________________

____________________________________________

____________________________________________

____________________________________________.

**Children (names & ages):** ____________________________________________

____________________________________________.

**History of Abuse:** Yes __________ No __________ If yes, explain to the best of your ability: ______________________

____________________________________________

____________________________________________

____________________________________________.

**Education:** (indicate highest degree received)

High School __________ Assoc Degree __________ College __________ Post Grad __________

Current Occupation & employer: ______________________________________________

______________________________________________.

Employment history (type of work, dates & employers): ______________________________________________

______________________________________________

______________________________________________

Termination(s) (reasons): ______________________________________________

**Health History:**
Please indicate:
(I) you (m) mother (f) father (s) sibling (g) grandparent

Have you or any family member ever had or been treated for any of the following:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies | ________ | Chronic Fatigue | ________ | Fibromyalgia | ________ | Irritable Bowel | ________ |
| Asthmas | ________ | Chronic Pain | ________ | Headache/Migraines | ________ | Skin Problems | ________ |
| Arthritis | ________ | Diabetes | ________ | Heart Disease | ________ | Stomach Problems | ________ |
| Back Trouble | ________ | Emotional Problems | ________ | High Blood Pressure | ________ | Ulcers | ________ |
| Cancer | ________ | Epilepsy | ________ | Hypoglycemia | ________ | Vision Problems | ________ |

Other (explain): ______________________________________________

______________________________________________.

Please list any hospitalizations (dates and reasons):

______________________________________________

______________________________________________.

Please list any medications you are currently taking:

______________________________________________

______________________________________________.

Date of Last Physical: ____________________ Name of physician: ______________________________

Clinic & Address: ______________________________________________

**Health Behaviors:**
Eating Habits (frequently overeat, erratic eating, frequent dieting, three meals a day): ______________________________

______________________________________________.

Rest/sleep patterns (how much, restful, fitful): ______________________________

______________________________________________.

Physical exercise (how often, what type): ______________________________

______________________________________________.

Use of alcohol/recreational drugs (frequency, amount, what kind, family history): ______________________________

______________________________________________.

Use of nicotine (frequency, amount, what kind, family history): ______________________________

______________________________________________.

Use of caffeine (frequency, amount, what kind): ______________________________

______________________________________________.

**Mental Health History:**
Are you suicidal? __________ Further Comments: ______________________________

Previous counselors and or psychiatrists (when, how often, how long, results):

Have you ever been admitted as an inpatient? (when, where, how long, for what?):

What symptoms are you currently experiencing? (anxiety, depression, irritability, sleep/eating problems, loss of interest, for how long?):

**Faith History:**
Describe your religious/spiritual life, significant experiences or events:

**Your goals for therapy are:**

Please expand on any questions listed above: