Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

BIOGRAPHICAL INFORMATION (ADULT)

Please fill out this biographical background form for yourself as completely as possible. It will help me in our work together. Information is confidential as outlined in the Outpatient Services Contract. You might decide to discuss some of the information requested in this form in person rather than providing a written response. If you do not desire to answer any question, merely write, "**Do not care to answer**." If you are pressed for time, please complete as much information as possible.

Date: _____

IDENTIFYING INFORMATION

Name(s): _____

Address: _____
_____
_____

Phone #: _____

E-Mail: _____

Name of Spouse/Partner: _____

Gender: ☐ Male ☐ Female ☐ Other: _____

Date of Birth: _____ Age: _____

REASONS FOR SEEKING THERAPY

1. Presenting Problem (Be as specific as you can: When did it start? How is it affecting your daily functioning?): _____
_____
_____
_____

2. Estimate the severity of above problem: ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

3. What have you tried so far to correct/manage the problem(s)? _____
_____
_____
_____

Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

4. Please list all previous counseling treatment.

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

5. Have you ever been evaluated by a psychiatrist or tested by a psychologist? Please list:

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

6. Have you ever sought counseling for your personal/marital life? Please list:

Dates	# of Sessions	Therapist	Problem Treated & Diagnoses	Reason for Termination

7. Have you ever been hospitalized for emotional reasons? If YES, please explain. _____

_____

_____

_____

8. Please list any developmental, emotional, learning or psychiatric diagnosis (along with the date when the diagnosis was given) that you have received in the past: _____

_____

_____

_____

9. Have you ever seen an occupational or physical therapist? If so, please include diagnoses. _____

_____

_____

_____

10. Do you suffer from any recurring pains and/or medical problems? If so, please describe. _____

_____

_____

_____

11. Please list any additional stressful/traumatic circumstances that have affected or are currently affecting you:

Relational Problems: _____
Financial Problems: _____
Legal Problems: _____
Educational Problems: _____
Housing Problems: _____
Physical Abuse: _____
Sexual Abuse: _____
Domestic Violence: _____
Medical Trauma/Problems: _____
Other: _____

12. How have you handled them up to now? _____
_____
_____
_____

13. Which of the aforementioned would you like help with? _____
_____
_____
_____

14. What areas of your life do you feel are affected by these problems? Please describe.

Home: _____
School: _____
Health: _____
Relationships: _____
Family Life: _____
Other: _____

15. Describe any changes in your:

Energy: _____
Sleep: _____
Appetite: _____
Other: _____

16. Have you ever had thoughts of harming another person?_____YES _____NO

If YES, describe when and how. _____
_____
_____

17. Have you ever had thoughts of harming yourself?_____YES _____NO

If YES, describe when and how. _____
_____
_____

CURRENT LIVING SITUATION

18. Are you: ☐ Single ☐ Co-habitating ☐ Married ☐ Separated ☐ Divorced ☐Widowed

19. Please list all the people you currently live with:

Name	Relationship	Age	Occupation	Employer/School

20. PARENTS' PRESENT and/or PAST MARRIAGE(S)

Number of mother's previous marriages? _____
Name of Mother's Partner(s): _____
Dates/Years:_____
Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _____
_____
_____
_____

Number of father's previous marriages? _____
Name of Father's Partner(s): _____
Dates/Years:_____
Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _____
_____
_____
_____

21. Siblings (If passed, provide age/year and cause of death).:

Name	Age	Nature of Relationship (i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

MEDICAL HISTORY

22. Medical Doctor(s) (name and phone): _____
_____

23. When was your last medical exam? _____
Doctor's Name: _____
Reason seen: _____
_____
_____

24. Past/Present Medical Care (major medical problems, surgeries, accidents, falls, head injuries, illness):
_____
_____
_____

25. List medications you are currently taking or took in the past.

Medication	Dosage	Dates Taken	Reason

26. Family medical history (Describe any illness that runs in the family – i.e., cancer, epilepsy, etc.): ____
_____
_____
_____

Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

ALCOHOL/DRUG USE HISTORY

27. Your current alcohol and drug consumption (please check appropriate answers):

Usual Alcohol Consumption: ☐ None ☐ 1-2 drinks per sitting ☐ 3-4 drinks per sitting ☐ 5+ drinks per sitting

Frequency of Alcohol Consumption: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

Frequency of Intoxication: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

Frequency of Drug Use: ☐ Never ☐ 1 time/month ☐ 1 time/week ☐ 2-3 times/week ☐ Daily

28. Have you or anyone else had concern about your drinking or drug use?_____NO_____YES

If YES, who and why? _____
_____
_____

29. Are you currently in a relationship with someone who uses alcohol and/or drugs?_____NO____YES

If YES, who and what do they use? _____
_____
_____

30. Does or did anyone in your family of origin (or significant person in her/his life) abuse alcohol and/or drugs? If YES, please state the relationship, drug, and pattern of use. _____
_____
_____
_____

FAMILY HISTORY

31. Is there history of the following? If YES, please describe who and helpful details.

Suicide	□ NO	□ YES	
Depression	□ NO	□ YES	
Psychiatric Problems	□ NO	□ YES	
Violence	□ NO	□ YES	
Alcohol/Drug Use	□ NO	□ YES	

32. Please list anyone that has died who was close to you and its impact on you. _____
_____
_____
_____

33. If you are divorced or separated, what was your age at the time? Describe its impact on you: _____
_____
_____
_____

CLINICAL & RISK ASSESSMENT

34. Areas of Clinical Concern: Please rate your level of concern regarding the following conditions:

	No Concern	Some Concern	Very Concerned	Elaborate if needed.
Depression				
Anxiety				
Impulsivity				
Hyperactivity				
Defiance				
Lack of Empathy				
Anger Control				
Suicide Risk				
Self-Mutilation				
Other Self-Harm				
Danger to Others				
Sexual Aggression				
Runaway				
Delinquency				

35. Usage of Technology: Please state your perception of your level of usage of the following:

	Low	Average	Excessive
Social Media			
Video Games			
Texting			
General Internet Use			
Television			

Anchor Psychology, Inc.
1975 Hamilton Ave.
Suites 11 & 37
San Jose, CA 95125

main: 408.340.5875
anchorpsychology.net

PERSONAL AND PROFESSIONAL INFORMATION

36. What is your highest level of education? _____

37. Are you: ☐ Working Full-Time ☐ Working Part-Time ☐ Working at Home ☐ Self-Employed
☐ Care-Taking ☐ Disabled ☐ Unemployed ☐ Retired

38. Current or Past Occupation: Provide job title, employer, and any concerns regarding occupation. _

_____

_____

_____

39. Friendships, Community, Social Support and Spirituality: Describe quality, frequency, activities, etc.

_____

_____

_____

40. Are you involved in any current or pending civil or criminal litigations, lawsuits, and/or divorce or custody disputes? If yes, please explain. _____

_____

_____

_____

41. What are your main worries and fears? _____

_____

_____

_____

42. What do you want for your future? _____

_____

_____

_____

43. Please add any other information you would like me to know about you and your family in terms of the past or a present situation. _____

_____

_____

_____