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Psychotherapy

Biographical Information and Intake Form

** All information is confidential as outlined in the Office Policy Agreement. Please fill out this form as much as you can. If you do not desire to answer any question, leave it blank.*

1) Biographical Information:

Name: _____ Date of Birth: _____
Age: _____ Gender: _____ Marital Status: _____ Birthplace: _____
Address: _____ City/State: _____
Zip: _____ Home #: (____) _____ Mobile #: (____) _____
Occupation: _____ Employer: _____
Employer Address: _____ Work #: (____) _____

Emergency Contact:

Name: _____ Relationship: _____
Phone #: (____) _____
Primary Care Physician: _____ Phone: (____) _____
Allergies: _____
How many people live in your household: _____

2) For Insurance holders:

Insurance Policy: _____ ID# _____
Group # _____ Social Security Number: _____

3) Presenting Problem (Be specific: When did it start, how does it affect you, etc.)

Current events, difficulties or symptoms that brought you in for psychotherapy:

How have you handled these stressors so far?

The following list describes a range of symptoms that people sometimes experience. Please indicate how much they affect your functioning (if applicable):

Write **0** if **“not at all”**

Write **1** if **“a little”**

Write **2** if **“somewhat”**

Write **3** if **“much”**

Write **4** if **“a lot”**

Write **“P”** if you have experienced **“in the past,”** not now.

Trouble falling asleep/waking up: _____
 Unintended appetite/weight changes: _____
 Feeling "guilty": _____ Feeling "empty": _____
 Tearfulness: _____
 Feeling hopeless or helpless: _____
 Physical complaints _____
 Feeling bad about the way you are: _____
 Avoidance: _____
 "Spacing out" or losing focus: _____
 Sexual problems: _____
 No interest in things you liked before : _____
 Having difficulties saying "no": _____
 Mood swings(noticed by self/others): _____
 Impulsive actions: _____
 Racing thoughts: _____
 Spending sprees: _____
 Feeling restless, interrupting people: _____
 Hearing voices/experiencing unique sensations: _____
 Feeling anxious/nervous: _____
 Experiencing "panic": _____
 Feeling "edgy" or impatient: _____
 Having nightmares: _____
 Being "alert or vigilant" often: _____

Getting into fights/arguments easily: _____
 Getting startled easily: _____
 Fears of getting out of the house: _____
 Phobias: _____ (Of what: _____)
 Worry that something bad will happen: _____
 Not sure *who* you are at times: _____
 Distressing thoughts pop in your mind: _____
 Feeling disconnected from your body: _____
 A certain preoccupation doesn't leave your mind: _____
 Trying to stop this preoccupation by doing specific things repeatedly _____
 Cutting/hurting/picking on self: _____
 Feeling as if your life was a movie and you're watching it _____
 Lying: _____ Stealing: _____
 Feeling suicidal: _____
 Having a plan to hurt yourself: _____
 Feeling like you want to hurt someone: _____ (who/how: _____)
 Feeling bad about the way you look: _____
 Trying not to eat for long periods of time: _____
 Vomiting after eating: _____
 Eating secretly in large amounts: _____

4) History of hospitalization/violent behavior/treatment:

Have you ever being psychiatrically hospitalized? If yes, please describe your age, circumstances, how long you stayed in the hospital, if it was voluntary or not:

Please describe ages/reasons/circumstances of any past suicide attempt or intention:

Please describe ages/reasons/circumstances of any past violent behavior/legal problems:

Please describe past and present psychotherapy (age, duration, type of counseling, medication, how helpful it was, overall impression, if the end was abrupt or mutually agreed upon.)

5) History of substance use/abuse/dependence:

Please describe any history of treatment (type: AA, detox, inpatient, group home, etc), duration, circumstances, your age)

Coffee: (# _____ cups daily) **Tobacco** (# _____ daily)

Alcohol (# _____ drinks daily or _____ weekly)

Date last drank: _____ What type of drink: _____

Prescription drugs -- used without medical need:

Type: _____ Frequency: _____

Street drugs: (list all types used)

Type (1): _____ frequency: _____

Type (2): _____ frequency: _____

Type (3): _____ frequency: _____

Type (4): _____ frequency: _____

6) Medical History:

Please describe any present/past medical issues, including interventions, treatment, allergies, and doctors' names:

Current medication (include dosage, frequency, name):

Psychotropic:

Non-psychotropic:

7) Childhood and Relationships:

Please describe your childhood: (how was school, home environment, transitions/changes, history of losses – of significant others, pets, pregnancy, etc, – any difficult/abusive or inspiring/nurturing relationships; history of drug or psychiatric illnesses in family; if parents divorced – how old you were.)

Please describe your current and past relationships (main relationships, trauma, marriages, children, divorce, losses, mentors, etc.)

8) Challenges and Strengths:

What are your strengths? (If you can't come up with anything, how do you think your best friend would describe you?)

What are your challenges?

9) What are you hoping to get from therapy?

Signature of Client/Legal Representative

Date

Printed Name