C. JASON EARLE, LCSW
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Biographical Patient Information Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

NAME: _____ MALE/FEMALE: _____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: _____

ADDRESS: _____

TELEPHONE: Home: _____ Cell: _____ Work/Office: _____ FAX: _____

FOR ROUTINE MESSAGES: Phone #_____ E-mail: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #_____ E-mail: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & PHONE NUMBER TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATION (former. if retired or not currently employed): _____

_____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you…):

_____

_____

Estimate the severity of above problem: Mild-Moderate-Severe-Very severe

CURRENT: Marital status: __ Live with someone: __ Name: _____Years: _

PAST & PRESENT MARRIAGE/S (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

_____

_____

_____

_____

_____

_____

_____

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PRESENT SPOUSE/PARTNER: Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1._____
2._____
3._____
4._____
5._____

PARENTS/STEP-PARENT (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:_____

_____

_____

Mother:_____

_____

_____

Step-parent(s):_____

_____

_____

SIBLINGS (name/age, if dead: age and cause of death & brief statement about the relationship):

1._____
2._____
3._____
4._____
5._____

MEDICAL DOCTOR/S (name /phone): _____

_____

_____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

_____

_____

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

_____

_____

_____

_____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

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_____

_____

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc)

_____

_____

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc):

_____

_____

_____

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

_____

_____

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

_____

_____

2. _____

_____

_____

3. USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

_____

_____

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time

_____

_____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

_____

_____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

_____

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What gives you the most joy or pleasure in your life?

_____

_____

What are your main worries and fears?

_____

What are your most important hopes or dreams?

_____

_____

Please include any additional information you would like me to know about you and your situation