CORI ROSENTHAL
M.A., LMFT

Biographical Information Form

Instructions: To assist me in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence. If certain questions do not apply to you, please leave them blank.

1) Name:____2) Age:____________3) Sex: M F

4) Address: ____
Street Numbers City State Zip

5) Today's Date:_____---___---___ 6) Date of Birth____---____---____

7) Home/Cell Phone:_______---_____---_______ 8) Business Phone:_______---_____---_______

9) Years of Education: _______ 10) Occupation: ____

11) Present Relationship Status (Check any that apply):

Married or in a primary relationship Dating One person Several Persons

Single: How long_______years. Other

12) If in a primary relationship or married, I have been in this relationship for________years.

COUNSELING HISTORY

14) Are you presently receiving other counseling services? Y N

If yes, please briefly describe: ____

____

15) Have you received counseling in the past? Y N

If yes, please briefly describe: ____

____

16) What is your main reason for coming to counseling: ______________________________

____

____

____

17) How long has this problem persisted? (from #16): ______________________________

18) Under what conditions do your problems usually get worse?: ______________________

____

19) Under what conditions are your problems usually improved?: ______________________

____

20) How did you hear about this therapist, or who referred you?: ______________________

MEDICAL HISTORY

21) Name and address of your physician(s):

a. Physician's name: ______________________________

Address: ______________________________

b. Physician's name: ______________________________

Address: ______________________________

22) List any major illnesses and/or operations you have had: ______________________

____

____

23) List any physical concerns you are presently having: (e.g. high blood pressure, headaches, dizziness, etc.) ____

____

24) List any physical concerns you have experienced in the past: ________________________________

____

____

25) When was your last complete physical exam?: ____

Results of physical exam: ____

26) On average how many hours of sleep do you get per day?: ________________

27) Do you have trouble falling asleep at night?: Yes No

28) Are you satisfied with your amount/quality of sleep?: Yes No

If no, please elaborate: ____

29) Have you gained/lost over ten pounds in the last year? Yes No

30) Does your weight affect the way you feel about yourself? Yes No

31) Have any members of your family suffered with an eating disorder? Yes No

32) Do you feel your weight or body image is affecting your life? Yes No

If yes, in what way: ____

____

33) How would you describe your appetite in the last week? ______________________________

34) What medications are you currently taking, and for what purpose?: ______________________________

____

____

RELIGIOUS CONCERNS

35) What is your present religious affiliation?:

Christian (please specify): ________________

Jewish

Muslim

Buddhist

None, but I believe in God

Atheist or Agnostic

Pagan/Wiccan

Other (please specify): ____________________

36) How important is religious commitment to you?

Unimportant			Average Importance				Extremely Important	
1	**2**	**3**	**5**	**6**	**7**	**8**	**9**	**10**

36) Do you desire having your religious beliefs and values incorporated into the counseling process?:

Yes No

(If yes, please explain): ____

FAMILY HISTORY

37) Mother's age: __________ if deceased, how old were you when she died?: ____________

38) Father's age: __________ if deceased, how old were you when he died?: ____________

39) If your parents are separated or divorced, how old were you then?: ___________

40) Number of brother(s):________Their ages: ___________________________________

41) Number of sister(s):________Their ages: ___________________________________

42) I was child number____________in a family of______________children.

43) Were you adopted or raised with parents other than your natural parents?: Yes______No _______

44) Briefly describe your relationship with your brothers and/or sisters: ________________________________

____

____

45) When of the following best describes the family in which you grew up?

WARM & ACCEPTING				AVERAGE		HOSTILE AND FIGHTING		
1	**2**	**3**	**5**	**6**	**7**	**8**	**9**	**10**

46) Which of these describes the way in which your family raised you?:

ALLOWED ME TO BE VERY INDEPENDENT				AVERAGE		ATTEMPTED TO CONTROL ME		
1	**2**	**3**	**5**	**6**	**7**	**8**	**9**	**10**

YOUR MOTHER (or mother substitute)

47) Briefly describe your mother: ____

____

48) How did she discipline you?: ____

____

49) How did she reward you?: ____

____

50) How much time did she spend with you when you were a child?

Much Average Little

51) Your mother's occupation when you were a child:

Stayed Worked outside part- Worked outside full-

52) How did you get along with your mother when you were a child?:

Poor Average Well

53) How do you get along with your mother now?

Poor Average Well

54) Did your mother have any problems (e.g. alcoholism, violence, etc.) which may have affected childhood development?: Yes No

55) Is there anything unusual about your relationship with your mother?: Yes No

(if Yes, please describe): ____

____

56) Describe overall how your mother treated the following people as you were growing up:
(Circle one answer for each)

YOUR MOTHER'S TREATMENT TO	Poor				Average					Excellent
a. YOU	1	2	3	4	5	6	7	8	9	10
b. YOUR FAMILY	1	2	3	4	5	6	7	8	9	10
c. YOUR FATHER	1	2	3	4	5	6	7	8	9	10

<u>YOUR FATHER</u> (or mother substitute)

57) Briefly describe your father: ____

____

58) How did he discipline you?: ____

____

59) How did he reward you?: ____

____

60) How much time did he spend with you when you were a child?

Much Average Little

61) Your father's occupation when you were a child:

Stayed   Worked outside part-   Worked outside full---time

62) How did you get along with your father when you were a child?:

Poor   Average   Well

63) How do you get along with your father now?:

Poor   Average   Well

64) Did your father have any problems (e.g. alcoholism, violence, etc.) which may have affected childhood development?

Yes   No

65) Is there anything unusual about your relationship with your father?:   Yes   No

(if Yes, please describe): ____

____

66) Describe overall how your father treated the following people as you were growing up:
(Circle one answer for each)

YOUR FATHER'S TREATMENT TO	Poor			Average				Excellent		
a. YOU	1	2	3	4	5	6	7	8	9	10
b. YOUR FAMILY	1	2	3	4	5	6	7	8	9	10
c. YOUR FATHER	1	2	3	4	5	6	7	8	9	10

THOUGHTS AND BEHAVIORS

67) Please check how often the following thoughts occur to you:

Life is hopeless	Never	Rarely	Sometimes	Frequently
I am lonely	Never	Rarely	Sometimes	Frequently
No one cares about me	Never	Rarely	Sometimes	Frequently
I am a failure	Never	Rarely	Sometimes	Frequently
Most people don't like me	Never	Rarely	Sometimes	Frequently
I want to die	Never	Rarely	Sometimes	Frequently
I want to hurt someone	Never	Rarely	Sometimes	Frequently
I am so stupid	Never	Rarely	Sometimes	Frequently
I am going crazy	Never	Rarely	Sometimes	Frequently
I can't concentrate	Never	Rarely	Sometimes	Frequently
I am so depressed	Never	Rarely	Sometimes	Frequently
God is disappointed in me	Never	Rarely	Sometimes	Frequently
I can't be forgiven	Never	Rarely	Sometimes	Frequently
Why am I so different?	Never	Rarely	Sometimes	Frequently
I can't do anything right	Never	Rarely	Sometimes	Frequently
People hear my thoughts	Never	Rarely	Sometimes	Frequently
I have no emotions	Never	Rarely	Sometimes	Frequently
Someone is watching me	Never	Rarely	Sometimes	Frequently
I hear voices in my head	Never	Rarely	Sometimes	Frequently
I am out of control	Never	Rarely	Sometimes	Frequently

PLEASE COMMENT (e.g., examples frequency, duration, their effects on you) ABOUT EACH OF THE ABOVE THOUGHTS WHICH OCCUR FREQUENTLY. Use the back of this sheet if necessary.

____

____

SYMPTOMS

68) Check any behaviors and symptoms you have that occur more often than you would like:

Aggression	Avoiding people	Dizzines	Hallucination
Alcohol dependence	Chest pain	Drug dependence	Heart
Anger	Depression	Eating disorder	High blood pressure
Antisocial behavior	Disorientation	Elevated mood	Hopelessness
Anxiety	Distractibility	Fatigue	Impulsiveness
Irritability	Judgement errors	Loneliness	Memory impairment
Mood shifts	Panic attacks	Phobias/fears	Recurring thoughts
Sexual difficulties	Sick often	Sleeping problems	Speech problems
Suicidal thoughts	Thoughts disorganized	Trembling	Withdrawing

Worryin Other (specify) ______________________________

GIVE EXAMPLES OF HOW EACH OF THESE WHICH YOU CHECKED IMPAIR FUNCTIONING (e.g., socially, emotionally, occupationally, physically, etc. (Use the back of this sheet if necessary).

____

____

____

69) List your five greatest strengths:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

70) List your five greatest weaknesses:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

71) List your main social difficulties: ______________________________

____

____

72) List your main love and sex difficulties: ______________________________

____

____

73) List your main difficulties at school or work: ______________________________

____

____

74) List your main difficulties at home: ______________________________

____

75) List your behaviors that you would like to change:

76) Additional information you believe would be helpful:

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