Suzanne Cleck PsyD

BIOPSYCHOSOCIAL HISTORY FORM

In preparation for our first appointment, please complete the following questions to the best of your ability. The information will help me to better understand your current life circumstances, your concerns, your strengths, and your goals for seeking psychotherapy. Feel free to leave blank any questions that are not relevant to you or that you would prefer not to answer.

IDENTIFYING INFORMATION:

Name:	Date of Birth: Age:	Sex:
Place of Birth:	City Where Primarily Raised:	Ethnicity:
Current Address:	Phone Numbers: Home: Cell: Work:	Occupation: Employer: City:

Present Relationship Status (please circle):	Single Married Co-Habitating Widowed Separated Divorced Dating
Partner's Occupation:	Partner's Employer:

Please list the people with whom you presently live.		
Name	Age	Relationship to You

In case of emergency, whom do I have permission to contact?	Relationship to You:
Emergency Contact Phone:	Emergency Contact Address:

PSYCHOTHERAPY GOALS:

How did you become aware of my services, or who referred you?
What would you like to work on in psychotherapy?
How did you decide that now is a good time to begin psychotherapy?

HEALTH AND WELLNESS:

Please indicate which wellness or lifestyle practices you engage in regularly by checking those that apply and elaborating to the right.

	Exercise (e.g. cardio, strength training, yoga)	
	Nutrition Practices	
	Time in Nature	
	Contemplative Practices (e.g. meditation, prayer, mindfulness)	
	Community Engagement (e.g. religious/spiritual congregation, support group, recreation group)	
	Community Service or Volunteer Activities	
	Supportive Relationships (e.g. friends, co-workers, clergy)	
	Creative Outlets (e.g. art, music, theater)	
	Recreational Activities (e.g. hobbies, what you do for fun)	
	Relaxation or Stress Management (e.g. breathing, guided imagery, aromatherapy)	
	Other	

Present State of General Health (please circle): Excellent Good Fair Poor
Please describe your present sleeping pattern (e.g. hours per night; restful or not; problems getting to sleep or waking early).
Please describe your eating patterns (e.g. number of meals & snacks per day, restrictions).

Please state significant medical problems for which you have been or are being treated.
Please list approximate dates and nature of any surgical procedures.
If you have had any head injuries, please describe, including approximate date(s).
Please list any other accidents or serious injuries.
If you have any disabilities that require accommodation, please describe.
Please list any allergies and indicate whether they are mild, moderate, or severe.
Please list any non-psychiatric medications (prescription and over-the-counter, prescribed supplements) you are taking, including dose and frequency. Use back of form if needed.
Please provide the approximate date of your last complete physical exam and the results.
Name of your present internist or physician:

How many biological children have you had?
Please describe the current state of your sexual health or functioning.
If you have ever experienced or been a partner to someone who has experienced pregnancy loss, please elaborate.
If you or a partner has ever experienced infertility or infertility treatment, please elaborate.

Please indicate the amount and frequency of use of the following.				
	Present Use		Past Use, if Different	
	Amount/Type	Frequency	Amount/Type	Frequency
Alcohol				
Nicotine				
Caffeine				
Other Substances				

MENTAL HEALTH:

Have you worked with a psychotherapist in the past? ____Yes. ____No. If so please give the approximate dates, type (i.e. individual, couple, family) and duration of the therapy(ies).
What was most useful to you in this work?
What do you wish could have been different or more helpful?

Please list any psychiatric medications (i.e. to treat anxiety, depression, inattention, disturbing thoughts, etc.) you have taken or are taking. If more space is needed, please use side or back.				
Medication	Dose	Start Date	End Date	Was it helpful?

Name of current psychiatrist or prescribing physician:
Have you ever had a psychiatric hospitalization? ____Yes. ____No. If so, please describe including dates, reason, and outcome.
Have you ever made or threatened to carry out a suicide attempt? ____Yes. ____No. If so, please give approximate date(s) and describe.

Have you ever harmed or threatened to harm another person? ____Yes. ____No. If so, please give approximate dates(s) and describe.
Has substance abuse ever been a problem for you? ____Yes. ____No. If so, please indicate the substance(s) of preference and duration of use.
If you have ever received treatment for substance abuse, please describe (e.g. inpatient, outpatient, approximate dates, outcomes).
Do you have a history of other addictive behaviors (e.g. food, gambling, sex, video games, media/technology)? ____Yes. ____No. If so, please describe.

FAMILY OF ORIGIN:

Please provide information about your parents/caregivers.				
	Parent	Parent	Step Parent or Other Caregiver	Step Parent or Other Caregiver
First Name				
Age				
City, State				
No. of Children				
Marital Status				
Education Level				
Occupation				
Physical Health*				
Mental Health*				
If Deceased, Cause/Age/Date				
* E = Excellent, G = Good, F = Fair, P = Poor				

Please provide information about your siblings in order of birth, including step/half siblings. Please use side or back if necessary.					
	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
First Name					
Age					
City, State					
Relationship Status					
No. of Children					
Education Level					
Occupation					
Physical Health*					
Mental Health*					
If Deceased, Cause/Age/Date					
* E = Excellent, G = Good, F = Fair, P = Poor					

Identify and describe a primary caregiver (e.g. mother, father, relative, step-parent) as you remember her/him during your life at home, including her/his characteristics as a person.
In general, how was your relationship with this primary caregiver?
Identify and describe another primary caregiver (e.g. mother, father, relative, step-parent) as you remember her/him during your life at home, including her/his characteristics as a person.
In general, how was your relationship with this caregiver?
How did your parents or caregivers get along with each other while you lived with them?
How are your relationships with each of your parents/caregivers now?
If you had siblings, describe your relationship with them during childhood.
If you have siblings, describe your relationship with them now?

While growing up, were you ever frightened by a family member? ____Yes. ____No. If so, please describe, including frequency and intensity.
Did you ever witness a family member(s) being frightened? ____Yes. ____No. If so, please describe, including frequency and intensity.
Please indicate relatives with a history of emotional or mental disorder or suicide. If known, please include diagnosis and treatment.
Please note relatives with a history of alcoholism, substance abuse or excessive alcohol use.
Have you ever experienced abuse or harassment? ____Yes. ____No. If so, please describe (e.g. physical, sexual, emotional), including when and by whom.
Growing up, what were your favorite rituals or traditions?

RELATIONSHIPS AND CURRENT FAMILY:

If applicable, please give the approximate date your present partner relationship began.						
If applicable, please provide information about your partner and/or children.						
	Partner	Child	Child	Child	Child	Child
First Name						
Age						
City, State						
Relationship Status						
No. of Children						
Education Level						
Occupation						
Physical Health*						
Mental Health*						
If Deceased, Cause/Age/Date						
* E = Excellent, G = Good, F = Fair, P = Poor						

If you have a current relationship with a significant other or partner, please describe your experience of the relationship.
What are the strengths of your relationship?
If you have any concerns about your partner relationship, including sexual ones, please describe them.
Please describe your partner, including her or his characteristics.
Please list any previous marriages or long-term relationships, including first name, year relationship began, year ended, and any children from this relationship.

If you are a parent, please describe your relationship with your children.
What has been most satisfying to you as a parent?
What has been most challenging to you as a parent?

RELATIONSHIP WITH SELF AND OTHERS (besides partner)

To whom, if anyone, do you typically turn for emotional support?
Briefly describe the nature and quality of your closest friendship(s).
Please describe any concerns you have about your friendships or friendship patterns.
What do you believe to be your strengths as a friend?
Describe your personality and temperament.
How do you prefer to seek comfort when you are distressed?

EDUCATION:

Please state your highest level of education, including discipline and degree.

Please describe the following for grade school, high school, and any higher education.			
	Grade School	High School Year graduated:_____	College/Grad School Year(s) graduated:_____
How were your grades?			
Describe your involvement in extra-curricular activities.			
Describe your relationship with other students, in general.			
Describe your relationship with teachers.			
If ever diagnosed with a learning disability or attention difficulty, please describe.			

WORK:

How long have you worked at your present job?
What are your specific work responsibilities?
How satisfied are you with your present job?
What aspects of your present job do you enjoy the most?
How are your relationships with your peers at work?
How are your relationships with supervisors?
Please list other significant jobs you have had along with approximate dates.
Please describe any significant problems in past/present job situations.

SPIRITUALITY/RELIGION:

If applicable, describe the role spirituality/religion has played in your life.
In what spiritual/religious faith, if any, were you raised?
If you have a present spiritual/religious community, please describe.
How often do you attend religious/spiritual services or activities?
Please describe any spiritual/religious practices you may have.
If applicable, please describe your spirituality or philosophy of life?

LEGAL:

Have you had any past litigation or legal problems? ____Yes. ____No. If so, please explain.

OTHER:

Is there anything else you would like me to know about you?
Do you have any questions for me that relate to our work together?

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Signature Verification Form

_____I understand that my information is protected by HIPPA. I understand that my insurance company will be informed that I am being treated.

_____I give Informed Consent, which means that I am being treated for a medical condition and I give my permission to be treated. There is no guarantee that by me receiving these services I will improve.

_____I understand that I am responsible for my deductible if I have one and that I am required to pay copays. If my insurance company does not cover behavioral health benefits I am required to pay for them.

_____I agree to pay this amount if I do not have insurance_____.

_____I understand that I am required to give 24 hour notice if I am unable to attend my scheduled appointment. I am responsible to cover the agreed upon fee. Emergency cancellation will be considered.

_____I understand that I have a responsibility to discuss my concerns with the above clinician.

Signature:	Date: