Jennifer Danhauser, LPC
Counseling and Therapy Services

Biographical Information Form

Personal and Relationship Information

Name:	Todays Date:
Date of Birth:	
Education level (Circle any that apply) GED High School Diploma Some college/training College graduate Graduate School Post Graduate Technical/Vocational School Degrees/Certificates Name('s):	What occupation(s) have you mainly been trained for? Your Present Occupation Title: Is your occupation (Circle One): Full time Part time
Names and ages of child or children (If any):	Briefly describe your relationship with your child or children:
Present relationship status:	Number of years in your current relationship:
Spouse/Significant Other's Occupation Title:	Spouse/Significant Other's Occupation (Circle One) Full time Part time
Briefly describe your relationship with your Spouse/ Significant:	Briefly describe your satisfaction with friendships:
Religious/Spiritual Beliefs:	Cultural Background:

Family History

Mother's age:	If deceased, how old were you when she died?
Briefly describe the type of person your mother (or stepmother or person who substituted for your mother) was when you were a child and how you got along with her? How would you described your relationship currently?:	
Father's age:	If deceased, how old were you when he died?
Briefly describe the type of person your father (or stepfather or father substitute) was when you were a child and how you got along with him? How would you described your relationship currently?:	
If your mother and father divorced/ended their relationship, how old were you at the time?	
If your mother and father did not raise you when you were young, who did?	
Were you adopted? Yes No	
Names and ages of living brothers (If any):	

Biographical Information Form, Cont.

Names and ages of living sisters (If any):
Were there any unusual events or disturbing features growing up or currently your family you wish to share? Briefly describe:

Treatment and Medical History

Approximate names and dates of previous mental health providers:
If you had previous providers, what was effective about the treatment and what was not?
Are you currently taking psychiatric medication? Yes No If yes, please list the medication (s): Prescriber's Name:
List your chief physical ailments, diseases, complaints, or handicaps: Primary Care provider's name:

Personal Evaluation

Briefly list your **present** primary complaints, symptoms, and problems:	
Under what conditions are your problems worse?	Under what conditions are they improved?
List the things you enjoy doing the most, the kinds of things or persons that give you pleasure:	
List your main positive traits:	List your main negative traits:
List your main social difficulties:	List your main school or work difficulties:
List your main life goals:	
List your main love and sex difficulties (if sexually active):	
Additional information that you think might be helpful:	