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Welcome to a very healthy step in making the life you want. Together we will look at your needs, goals, and challenges. Filling out these forms speeds the process along.

I am here to help you, guide you, and give you hope, therefore, filling out this information packet makes my job much easier and our first session will be much more productive for you. May God bless and guide our work together.

Blessings to you,

Dr. Baker

Biographical Questionnaire – CONFIDENTIAL

Client Initials & Date Completed:_____ Mental Health Professional Initials: _____

(More space is available on the last page to expand on any question)

Name(s): _____

Address: _____

Date of Birth: _____E-Mail:_____

Personal History:

Single _____Married _____Name of Spouse _____
Divorced_____ Name of Ex-Spouse(s) _____

No. of Marriages_____ Other _____

Dates of Marriage(s) and divorce(s): _____

_____

Birthplace:_____ Relocation (when & where): _____

_____

_____

Children (names & ages as well as the city and state where they live if they don't live at home):

_____

_____

_____

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Memories and emotional qualities of growing up years (i.e. parents' relationship, your relationship with them, with siblings, any family crisis, trauma):

Parents: If living, age and health status: _____

If deceased, when and cause: _____

Brothers and/or Sisters: (how many, names, ages, and where they live):

Relational and/or marital history (significant relationships, when, length of time, emotional qualities of):

_____

_____

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_____

History of Abuse: Yes _____No ___If yes, explain to the best of your ability: ____

_____

_____

Education: (indicate highest degree received)

High School _____Associates Degree __College _____Post Graduate _____

Current occupation & employer: _____

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Employment history (type of work, dates & employers):

Termination(s) (reasons):

Health History:

Please indicate: (I) you (m) mother (f) father (s) sibling (g) grandparent

Have you or any family member ever had or been treated for any of the following:

Allergies		Diabetes		Hypoglycemia	
Asthma		Emotional Problems		Irritable Bowel	
Arthritis		Epilepsy		Skin Problems	
Back Trouble		Fibromyalgia		Stomach Problems	
Cancer		Headache/Migraines		Ulcers	
Chronic Fatigue		Heart Disease		Vision Problems	
Chronic Pain		High Blood Pressure			

Other:

Please list any hospitalizations (dates & reasons):

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Please list any medications you are currently taking: _____

_____

_____

Date of last physical:_____ Name of physician: _____

Clinic & Address: _____

_____

Health Behaviors:

Eating habits (frequently overeat, erratic eating, frequent dieting, three meals a day): _____

_____

_____

_____

Rest/sleep patterns (how much, restful, fitful): _____

_____

_____

Physical exercise (how often, what type): _____

_____

_____

_____

Use of nicotine (frequency, amount, what kind, family history): _____

_____

_____

Use of caffeine (frequency, amount, what kind): _____

_____

_____

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Use of alcohol/all drugs – prescription or illegal (frequency, amount, what kind, family history):

Mental Health History:

Are you suicidal: _____Further comments: _____

Previous counselors and/or psychiatrists (when, how often, how long, results): _____

Have you ever been admitted as an inpatient? (when, where, how long, for what?):_____

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What symptoms are you currently experiencing? (Anxiety, depression, irritability, sleep/eating problems, loss of interest, for how long?):

Faith History:

Describe your religious/spiritual life, significant experiences or events:

Your Goals for Therapy are:

Please expand on any questions listed above:

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Is there anything else about you or your life's journey, thus far, that would be helpful for me to know?

May God bless this new path as you learn to take better care of yourself and change negative thoughts to positive ones.

Dr. Baker

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