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Biographical Information Form—Adult

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

Personal History

- 1) Name: _____ 2) Age: _____ 3) Gender: M F
4) Address: _____ City: _____ State: _____ Zip: _____
5) Weight: _____ 6) Height: _____ 7) Eye color: _____ 8) Hair color: _____ 9) Race: _____
10) Today's date: _____ 11) Date of birth: _____ 12) Years of education: _____
13) Occupation: _____ 14) Home phone: _____ 15) Business phone: _____
16) Present marital status:
____ 1) never married ____ 5) separated
____ 2) engaged to be married ____ 6) divorced and not remarried
____ 3) married now for first time ____ 7) widowed and not remarried
____ 4) married now after first time ____ 8) other (specify) _____
17) If married, are you living with your spouse at present? Yes No
18) If married, years married to present spouse: _____

Counseling History

- 19) Are you receiving counseling services at present? Yes No
If Yes, please briefly describe: _____

20) Have you received counseling in the past? Yes No
If Yes, please briefly describe: _____

21) What is (are) your main reason(s) for this visit? _____

22) How long has this problem persisted (from #21)? _____

23) Under what conditions do your problems usually get worse? _____

24) Under what conditions are your problems usually improved? _____

25) How did you hear about this clinic, or who referred you? _____

26) Name and address of your primary physician:
Physician's name: _____
Address: _____

27) List any major illnesses and/or operations you have had: _____

28) List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.):

29) List any other physical concerns you are having at present: _____

30) When was your most recent complete physical exam? _____
Results of physical exam: _____

31) On average how many hours of sleep do you get daily? _____

32) Do you have trouble falling asleep at night? Yes No
If Yes, describe: _____

33) Have you gained/lost over ten pounds in the past year? Yes No, _____ gained _____ lost
If Yes, was the gain/loss on purpose? Yes No

34) Describe your appetite (during the past week):
 poor appetite average appetite large appetite

35) What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

- 36) What is your present religious affiliation?
- ___ 1) Catholic
 - ___ 2) Jewish
 - ___ 3) Protestant (specify denomination if any) _____
 - ___ 4) None, but I believe in God
 - ___ 5) Atheist or agnostic
 - ___ 6) Other (please specify) _____
 - ___ 6) None

37) How important is religious commitment to you?

Unimportant	Average importance			Extremely important		
1	2	3	4	5	6	7

38) Do you desire to have your religious beliefs and values incorporated into the counseling process?
 Yes No Not sure (If Yes, please explain): _____

39) Mother's age: _____ If deceased, how old were you when she died? _____

40) Father's age: _____ If deceased, how old were you when he died? _____

41) If your parents separated or divorced, how old were you then? _____

42) Number of brother(s) ____ Their ages: ____ ____ ____ ____ ____

43) Number of sister(s) ____ Their ages: ____ ____ ____ ____ ____

44) I was child number ____ in a family of ____ children.

45) Were you adopted or raised with parents other than your natural parents? Yes No

46) Briefly describe your relationship with your brothers and/or sisters: _____

47) Which of the following best describes the family in which you grew up?

Warm and accepting	Average				Hostile and fighting			
1	2	3	4	5	6	7	8	9

48) Which of the following best describes the way in which your family raised you?

Allowed me to be	Average				Attempted to			
very independent					control me			
1	2	3	4	5	6	7	8	9

Your Mother (or mother substitute)

49) Briefly describe your mother: _____

50) How did she discipline you? _____

51) How did she reward you? _____

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

much average little

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

stayed home worked outside part-time worked outside full-time

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

poorly average well

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

poorly average well

56) Did you mother have any problems (e.g., alcoholism, violence, etc.) that may have affected your childhood development? Yes No

If Yes, please describe: _____

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

If Yes, please describe: _____

58) Describe overall how your mother treated the following people as you were growing up:

(Circle one answer for each)

Your mother's treatment of:	Poor			Average			Excellent	
1) You	1	2	3	4	5	6	7	
2) Your family	1	2	3	4	5	6	7	
3) Your father	1	2	3	4	5	6	7	

Your Father (or father substitute)

59) Briefly describe your father: _____

60) How did he discipline you? _____

61) How did he reward you? _____

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

much average little

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

stayed home worked outside part-time worked outside full-time

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

poorly average well

65) How do you get along with your father now?

poorly average well

66) Did you father have any problems (e.g., alcoholism, violence) that may have affected your childhood development? Yes No

If Yes, please describe: _____

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

If Yes, please describe: _____

68) Describe overall how your father treated the following people as you were growing up:

(Circle one answer for each)

Your father's treatment of:	Poor			Average			Excellent	
1) You	1	2	3	4	5	6	7	
2) Your family	1	2	3	4	5	6	7	
3) Your mother	1	2	3	4	5	6	7	

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

- 1) Life is hopeless. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 2) I am lonely. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 3) No one cares about me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 4) I am a failure. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 5) Most people don't like me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 6) I want to die. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 7) I want to hurt someone. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 8) I am so stupid. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 9) I am going crazy. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 10) I can't concentrate. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 11) I am so depressed. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 12) God is disappointed in me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 13) I can't be forgiven. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 14) Why am I so different? ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 15) I can't do anything right. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 16) People hear my thoughts. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 17) I have no emotions. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 18) Someone is watching me. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 19) I hear voices in my head. ___ Never ___ Rarely ___ Sometimes ___ Frequently
- 20) I am out of control. ___ Never ___ Rarely ___ Sometimes ___ Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thought that occur frequently or are a concern to you. Use the back of this sheet is necessary.

Symptoms

70) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|-------------------------|-------------------------|---------------------------|
| ___ aggression | ___ fatigue | ___ sexual difficulties |
| ___ alcohol dependence | ___ hallucinations | ___ sick often |
| ___ anger | ___ heart palpitations | ___ sleeping problems |
| ___ antisocial behavior | ___ high blood pressure | ___ speech problems |
| ___ anxiety | ___ hopelessness | ___ suicidal thoughts |
| ___ avoiding people | ___ impulsivity | ___ thoughts disorganized |
| ___ chest pain | ___ irritability | ___ trembling |
| ___ depression | ___ judgment errors | ___ withdrawing |
| ___ disorientation | ___ loneliness | ___ worrying |

76) List your main difficulties at home: _____

77) List your behaviors you would like to change: _____

78) Additional information you believe would be helpful: _____

PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS
OFFICE AT LEAST TWO DAYS BEFORE YOUR NEXT APPOINTMENT.