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Please fill out the biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy Form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring this form with you to the first session.

Name:______________________________________Male/Female:_______Date:________

Address:____

Telephone: H:_____________ W/Off:____________ Cell:___________ Fax:_________

Routine Messages: Phone:__________________ E-mail:___________________________

Confidential Messages: Phone_______________ E-mail:___________________________

Emergency Contact: Name:_____________________________Phone:________________

Date/Place of Birth:_______________________________________Age:_______________

Referral Source:____

Highest Grade/Degree:__________________________Type of Degree:_______________

Occupation: (former if retired):____

Presenting Problem:(be as specific as you can: when did it start, how does it affect you):

____

____

____

____

Estimate the severity of above problem: Mild Moderate Severe Very Severe

What made you decide to seek help at this specific time? __________________________

CURRENT: Marital Status:______________________ Live with someone:___________

Name:____ Years:__________________

PAST & PRESENT MARRIAGE/S (years together, names and statement about the nature of the relationship/s, i.e., friendly, physically/emotionally abusive, loving, hostile):

____

____

____

PRESENT SPOUSE/PARTNER:____

SPOUSE/PARTNER: Education:_________________Occupation:__________________

CHILDREN/STEP/GRAND (names, ages, & brief statement about your relationships)

1.____

2.____

3.____

4.____

5.____

PARENTS/STEP-PARENTS (name, age, year/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

Father:____

____

____

Mother:____

____

____

Step-parents:____

SIBLINGS (names, age, if dead; age and cause of death, brief statement about the relationship):

1.____

2.____

3.____

4.____

5.____

MEDICAL DOCTOR/S (name/phone):

____

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illnesses):

____

____

CURRENT/PAST MEDICATIONS (kind, amount, reasons)

____

____

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments):

____

____

SUICIDE ATTEMPTS OR VIOLENT BEHAVIOR (describe; ages, reasons, circumstances, how, etc.):

____

____

FRIENDSHIPS/COMMUNITY/SPIRITUALITY (describe quality, frequencies, activities, etc.):

FAMILY MEDICAL HISTORY (describe any illnesses that run in the family; cancer, epilepsy, addictions, etc.):

____

____

PAST/PRESENT PSYCHOTHERAPY (specify months/years, beginning/end, estimated number of sessions, name, degree, address, phone of therapists, initial reasons for therapy, Individual, Couples, Family Therapy, medications, brief description of the relationship and how helpful it was and how/why it ended);

____

____

____

____

DESCRIBE YOUR CHILDHOOD (relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavior problems, abusive/alcoholic parent):

____

____

____

____

____

IF PARENTS DIVORCED: Your age at the time:________ Please describe how it affected you at the time:

____

____

____

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLANCE (including suicide, depression, hospitalizations, abuse, etc.):

____

____

____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUITES, DIVORCE OR CUSTODY DISPUTES? (if yes, please explain):

____

____

What gives you the most joy or pleasure in your life?

____

____

What are your main worries and fears?

____

____

What are your most important hopes or dreams?

____

____

Please add on the other side of the page or on a separate page, any other information you would like Dr. Kobel to know about you and your situation.