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Biographical Patient Information Intake Form

Please fill out this 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 it with you to the first session.

DATE : _____

NAME: _____ M/F or Other: _____

DATE OF BIRTH/PLACE: _____ AGE: _____ Last 4 of SS# _____

ADDRESS: _____

TELEPHONE: H: _____ Cell: _____

FOR ROUTINE MESSAGES: Phone # _____ E-mail: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone# _____

E-mail: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & PHONE NUMBER TO CALL IN EMERGENCY: _____

REFERRAL SOURCE Psychology Today _____ Physician _____ (Physician's Name) _____

Other Web Search _____ Other (please be specific): _____ Insurance Provider _____

OCCUPATION (former. if retired): _____

PRESENTING PROBLEM (be as specific as you can)

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

CURRENT: Marital status: _____ Live with someone: _____

Name: _____ Years: _____

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

PRESENT SPOUSE/PARTNER: _____

Education: _____ Occupation: _____

CHILDREN/STEP/GRAND (names/ages & brief statement on your relationship with the person)

1. _____
2. _____
3. _____
4. _____
5. _____

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

Father: _____

Mother: _____

Step parents _____

SIBLINGS (name/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, illness): _____

SPECIFY MEDICATION you are presently taking and for what. PRINT clearly:

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

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (describe: ages, reasons, circumstances, how, etc)

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: cancer, epilepsy, etc):

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.):

Hours of Sleep per Night (On Average): _____ Issues sleeping? _____

Do you currently engage in a regular exercise regimen: Yes _____ No _____

If so, what is your regimen consist of:

If no, what is keeping you from regular exercise:

Tell us about your nutritional habits:

PAST/PRESENT PSYCHOTHERAPY (specify: month year/s (beginning—end), estimated no. of sessions, name, degree, phone & address, initial reason for therapy, Ind/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

3. _____

USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

DESCRIBE YOUR CHILDHOOD IN GENERAL (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

IF PARENTS DIVORCED: Your age at the time: _____, Describe how it affected you at the time

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if you answer Yes, please explain):

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

What are your main worries and fears? _____
