

Pinnacle Psychology Associates, PLC
44121 E. Harry Byrd Hwy
Suite 255
Ashburn, VA 20147

Biographical Information Form

Name: _____

What is your reason for seeking therapy at this point? _____

How long has this been a problem for you? _____
Did any thing seem to set off this problem for you? Yes____ No____ If yes, please describe what happened: _____

Does your problem(s) seem to be staying the same____, getting worse____, or getting better____?
Has anyone else been encouraging/pressuring/forcing you to seek help? Yes____ No____

Please check the symptoms below that occur to you more often than you would them to take place:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> addiction | <input type="checkbox"/> aggression | <input type="checkbox"/> alcohol use | <input type="checkbox"/> anger |
| <input type="checkbox"/> anorexia | <input type="checkbox"/> anxiety | <input type="checkbox"/> appetite loss | <input type="checkbox"/> avoiding people |
| <input type="checkbox"/> binge eating | <input type="checkbox"/> chest pain | <input type="checkbox"/> confusion | <input type="checkbox"/> compulsions |
| <input type="checkbox"/> crying | <input type="checkbox"/> depression | <input type="checkbox"/> disorientation | <input type="checkbox"/> disorganization |
| <input type="checkbox"/> dissociation | <input type="checkbox"/> distractible | <input type="checkbox"/> dizzy | <input type="checkbox"/> domestic violence |
| <input type="checkbox"/> drug use | <input type="checkbox"/> elation | <input type="checkbox"/> energy is low | <input type="checkbox"/> failure |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> fear | <input type="checkbox"/> gambling | <input type="checkbox"/> guilt |
| <input type="checkbox"/> hair pulling | <input type="checkbox"/> hallucinations | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> heart pounding |
| <input type="checkbox"/> heart racing | <input type="checkbox"/> hoarding | <input type="checkbox"/> hopelessness | <input type="checkbox"/> indecision |
| <input type="checkbox"/> infidelity | <input type="checkbox"/> impulsivity | <input type="checkbox"/> irritability | <input type="checkbox"/> irresponsibility |
| <input type="checkbox"/> jealousy | <input type="checkbox"/> lonely | <input type="checkbox"/> loss of control | <input type="checkbox"/> memory loss |
| <input type="checkbox"/> mood instability | <input type="checkbox"/> nightmares | <input type="checkbox"/> numbness | <input type="checkbox"/> obsessions |
| <input type="checkbox"/> overeating | <input type="checkbox"/> overwhelmed | <input type="checkbox"/> panic attacks | <input type="checkbox"/> perfectionism |
| <input type="checkbox"/> phobia | <input type="checkbox"/> physical illness | <input type="checkbox"/> pleasure loss | <input type="checkbox"/> pornography |
| <input type="checkbox"/> racing thoughts | <input type="checkbox"/> recurring thoughts | <input type="checkbox"/> restlessness | <input type="checkbox"/> self esteem is low |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> social anxiety |
| <input type="checkbox"/> stealing | <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> tension | <input type="checkbox"/> trauma |
| <input type="checkbox"/> trembling/shaking | <input type="checkbox"/> worry | <input type="checkbox"/> worthless feeling | |

Symptoms not listed above or additional details you would like to provide about the symptoms listed above: _____

Have you participated in therapy before? Yes ___ No ___ How many times? _____
Why did you seek therapy in the past? _____

Who provided therapy to you? _____
How long did you participate in therapy? _____
How helpful was your prior therapy? None ___ Somewhat ___ Very helpful ___
To what do you attribute the success or failure of your prior therapy? _____

Please provide information about additional episodes of therapy on the back of this page.

Have any other members of your family experienced a psychiatric/emotional disorder? Yes ___ No ___
How are you related to this person(s)? _____
What was the family member's diagnosis and what kind of treatment, if any, did your family member undergo? _____

Medical History:

List any major illnesses, injuries, and/or operations you have had: _____

List any physical problems you are having at present: _____

When was your most recent physical exam? _____ What were the results? _____

Please list information about your current medications below:

Medication Name	Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you exercise on a regular basis? Yes ___ No ___
What type of exercise you do? _____
How many times a week do you exercise? _____ For how many minutes per session? _____

On average, how many hours of sleep do you get per night? _____
Do you have trouble falling asleep? Yes ___ No ___
Do you wake up during the night? Yes ___ No ___
Do you wake up too early in the morning? Yes ___ No ___
Do you sleep too much? Yes ___ No ___

Have you gained or lost weight recently? Yes ___ No ___
Was the weight loss/gain intentional? Yes ___ No ___
How is your appetite? Poor ___ Okay ___ Too good ___
Do you think that you eat a relatively well balanced, nutritious diet? Yes ___ No ___

Do you feel more, tired, lethargic, or low in energy than usual? Yes ___ No ___

Partnership/marital relationship(s) and children:

How many times have you lived with someone in a committed relationship or been married? ___
Currently, are you currently single ___ dating casually ___ dating one person ___ married ___
separated ___ divorced ___ living with a significant other ___?
If married or living with a significant other, how long have you been together or married? _____
How well do you and your spouse/significant other get along?
Very poorly ___ Not so well ___ Okay ___ Good ___ Excellently ___
How many children do you have and what are their ages and gender? _____

What do you consider to be the purpose of marriage? _____

Are you satisfied with your current spouse/partner? Yes ___ No ___
Are you satisfied with your current relationship with your children? Yes ___ No ___

Friendships:

Do you consider yourself to be outgoing, shy, or in the middle? _____
How important are friendships to you? _____
Do you have close friends? Yes ___ No ___ Are they local? Yes ___ No ___
In the course of your average month, how often do you spend time with friends? _____
How well do you get along with people outside your family?
Very poorly ___ Not so well ___ Okay ___ Good ___ Excellently ___
Are you satisfied with your current friendship status? Yes ___ No ___

Education:

Are you currently in school? Yes ___ No ___
If yes, what school are you attending? _____
What are you studying? _____
How many courses are you taking per quarter or semester? _____
What is your highest educational degree? High School ___ Bachelors ___ Masters ___ Doctorate ___
What is/was the name of the last college attend? _____
What was your major? _____
How well did you do or are you doing in school? Not so well ___ Okay ___ Good ___ Excellently ___
Are you satisfied with your educational achievement? Yes ___ No ___

Employment:

Where do you work? _____
What kind of work do you do? _____
What is the purpose of work? _____
How well do you function at work? Very poorly ___ Not so well ___ Okay ___ Good ___ Excellently ___
Are you satisfied with your current employment status? Yes ___ No ___

Spirituality:

How important is spirituality/religion to you? _____
What religion were you raised in? _____
Are you currently a member of a religion? Yes___ No___ If yes, which one? _____
Are you satisfied with your current spiritual/religious practice? Yes___ No___

Self Care:

How important to you is time to yourself? _____
Do you get enough time daily to take care of yourself? Yes___ No___
What kind of leisure activities/hobbies do you enjoy? _____
How well are you managing your finances?
Very poorly___ Not so well___ Okay___ Good___ Excellently___
How well are you handling routine chores e.g. laundry, cleaning, cooking?
Very poorly___ Not so well___ Okay___ Good___ Excellently___
Are you satisfied with your self-care status? Yes___ No___

Substance Use:

Do you drink alcoholic beverages on a regular basis? Yes___ No___
If yes, what is your preferred beverage(s)? _____
How many drinks do you have per day _____ or per week _____ or per month? _____
Are you concerned about the way you drink alcohol? Yes___ No___
Is anyone close to you concerned about the way you drink alcohol? Yes___ No___
Do you take any recreational drugs besides alcohol on a regular basis? Yes___ No___
If yes, what recreational drugs do you take? _____
How often do you take recreational drugs? _____
Are you concerned about your use of recreational drugs? Yes___ No___
Is anyone close to you concerned about the way you use recreational drugs? Yes___ No___
Does anyone in your family have a history of alcohol/drug abuse/dependence? Yes___ No___
If yes, what relationship does this person(s) have to you? _____
Do you smoke cigarettes? Yes___ No___
If yes, how many packs do you smoke a day? _____
Do you drink caffeinated beverages? Yes___ No___
If yes, how many 12 ounce cups do you drink daily? Coffee___ Soda___

Family History:

Regarding your mother: Age___ If deceased, how long ago did she die? _____
Occupation: _____ If retired, her previous occupation: _____
Regarding your father: Age ___ If deceased, how long ago did he die? _____
Occupation: _____ If retired, his previous occupation: _____
How well did you parents get along with each other? (circle the answer below)
Very poorly Not too well Okay Pretty well Very well
Are your parents separated? Yes___ No___ Divorced? Yes___ No___
If divorced, have they remarried? Mother: Yes ___ No ___ Father: Yes___ No ___
Were you adopted or raised by parents other than your biological parents? Yes ___ No ___
How many brothers do you have _____ and what are their ages? _____

How many sisters do you have _____ and what are their ages? _____
Was or is your family unusual in any way? Yes____ No____ If yes, please describe: _____

Did anything unusual happen to you while you were growing up? Yes____ No____ If yes, please
Describe: _____

Which members of your family were you particularly close to and why? _____

Which members of your family were a source of hurt or pain to you and why? _____

What are your strengths?

- 1.
- 2.
- 3.
- 4.
- 5.

What are your weaknesses?

- 1.
- 2.
- 3.
- 4.
- 5.

To what do you attribute your successes in life? _____

To what do you attribute your failures in life? _____

Which of the following best describes your level of general happiness and wellbeing?

Very poor____ Less than desirable____ Okay____ Good____ Excellent__