Individual Background Information Form

Date_____

First Name _____ Middle Initial_____ Last Name_____

Date of Birth_____

Home Phone _____ Cell Phone _____

Home Address _____

Email Address (if you choose to communicate by email) _____

Occupation: _____

Primary Care Physician:_____

Known medical problems/current medications: _____
_____
_____

Any history of suicidal thoughts or suicide attempts?:_____
_____
_____

Briefly describe what you hope to accomplish in therapy:
_____
_____
_____
_____

How were you referred (please list name of contact or referral source):
_ Crisis Clinic
_ Friend/Family: _____
_ Web Search
_ Other: _____