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CLIENT IDENTIFYING INFORMATION

Please fill out this biographical background form as completely as possible. It will help me in our work together. You can either email it back to me at healingpeace.linda@gmail.com as an email attachment, or bring it with you to our first session.

Information is confidential as outlined in the Consent form and Notice of Privacy Practices. Please type or write clearly.

Client Name: _____

Parent(s)/guardian(s) (if under 18 years):

Birth Date: ____ / ____ / ____ Age: ____ Gender: ☐ Male ☐ Female ☐ Other

How do you identify, culturally (ethnicity, race, religion, etc.)? _____

Address: _____ (Number and Street)

_____ (City) (State) (Zip)

Primary Phone: (____) _____

May I identify myself? ☐ Yes ☐ No

Secondary Phone: (____) _____

May I identify myself? ☐ Yes ☐ No

E-mail: _____

May I email you? ☐ Yes ☐ No

**Note: Email correspondence is NOT considered to be a confidential mode of communication.*

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list any children/ages:

Emergency Contact (Name/Relation/Phone):

1. _____

2. _____

How did you hear about me? _____

GENERAL HEALTH & MENTAL HEALTH INFORMATION PRESENTING PROBLEM

Be as specific as you can: What brings you in, when did it start, how does it affect you.

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

Have you ever received any type of mental health services (psychotherapy, groups, testing/assessment, psychiatric services, etc.)? ☐ Yes ☐ No

Names/types of practitioners/duration of treatment: _____

Current vitamins/supplements and/or prescribed medications, if any:

Name	How Much?	How Often?	Date Began	Purpose

Current or previous prescribed psychiatric medication, if any:

Name	How Much?	How Often?	Date Began/Ended	Purpose

1. How would you rate your current physical health? Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

Medical Doctor (Name/Phone): _____

2. How would you rate your current sleeping habits? Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

3. How many times per week do you generally exercise/type? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ☐ No ☐ Yes If yes, please describe: _____

8. Do you drink alcohol more than once a week? ☐ No ☐ Yes If yes, how often/amount: _____

9. How often do you engage recreational drug use? Daily Weekly Monthly Infrequently Never
Type(s) _____

10. Are you currently in a romantic relationship? ☐ No ☐ Yes If yes, for how long? _____
On a scale of 1 to 10 (10 being best), how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

PERSONAL AND FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history – including yourself – of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please Circle	List Self or Family Member(s)
Alcohol/Substance Abuse	Yes No	
Anxiety	Yes No	
Attention Deficit Disorder	Yes No	
Depression	Yes No	
Domestic Violence	Yes No	
Eating Disorder	Yes No	
Mood Disorder	Yes No	
Obsessive Compulsive Disorder	Yes No	
Schizophrenia	Yes No	
Suicide Attempts	Yes No	
Violent/Assaultive Behaviors	Yes No	
Other (Describe)		

HISTORY

1. Briefly describe or list significant events from your CHILDHOOD (e.g., relationship with parents, siblings, divorce, school/behavioral problems, moves, trauma):

2. Briefly describe or list your SOCIAL SUPPORT (e.g., friendships, spiritual community):

3. Briefly describe or list your EDUCATION (e.g. highest grade/degree, academic performance/interests):

4. Are you involved in any current or pending CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (If yes, please explain):

ADDITIONAL INFORMATION

1. Do you currently have employment/source of income? ☐ No ☐ Yes

Please describe: _____

2. Do you enjoy your work? Is there anything stressful about your current work?

3. Do you adhere to certain faith/spiritual beliefs or practices? Please describe. _____

4. What do you consider to be some of your strengths? _____

5. What do you consider to be some of your weaknesses? _____

6. What would you like to accomplish out of your time in therapy? _____
