Background Information Sheet

Client Name:________________________ Sex__________ Birthdate______________

Referred by:________________________

Problem (s) for which you seek help:____

Previous Mental Health Services/dates:____

Background Information:

Childhood/Siblings:____

____

Parents: i.e. their personalities and your relationships with them:

____

____

____

Education:____

Religion:____

Employer:_________________________ Position:________________________

Marital Status:_____________ Name of Spouse___________ Dob__________

Nature of Relationship:____

____

Children (ages and sex):____

Interests and Recreational Pursuits:____

____

Medical Problems, allergies, and medications (dosages):________________________________

____

Primary Care Physician:_______________ Address/Phone #:_________________________