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Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the Office Policy form. 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.

NAME: _____ MALE/FEMALE: ____ DATE: _____

DATE OF BIRTH/PLACE: _____ AGE: ____

ADDRESS: _____

TELEPHONE: H : _____ W: _____ FAX: _____

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON AND PHONE NO. TO CALL IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATION (former. if retired): _____

PRESENTING PROBLEM (be as specific as you can: When did it start, how does it affect you...):

Estimate the severity of the above problem:

Mild__ Moderate__ Severe __ Very severe __

CURRENT: Marital status: __ Live with someone: __ Name: _____ Yrs: __

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. _____

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: _____

Stepparents _____

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 all **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** (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.):

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. _____

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, METAL ILLNESS, OR VIOLENCE
(including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

What gives you most joy or pleasure in your life:

What are your main worries and fears:

What are your most important hopes or dreams:

Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation