FREEDOM COUNSELING CENTER MN

(aka Andros Family Services)
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BIOGRAPHICAL INFORMATION FORM (ADULT)

INSTRUCTIONS: To assist us in helping you, please fill out this form as fully and openly as possible.

Please submit this online before your session. If unable to do online, please print and mail or bring to first session. Your thoroughness helps us to help you. Thank you.

PERSONAL HISTORY

Today's Date mm-dd-yyyy

Name **Age**

Birth Date mm-dd-yyyy **Sex** **Male** ○ **Female** ○

Address

City **State** **Zip**

Phone (home)

Phone (cell) **Email**

Phone (work)

Years of Education **Occupation**

Are you satisified with your present occupation?

I give my permission to be called at

Home? **Work?**

May we contact you for appointment reminders or schedule changes by?

Text ? **Email?** **Phone?**

Present Marital Status:

Never Married ○ **Engaged to be Married** ○ **Married now first time** ○

Married 2nd Time or More ○ **Separated** ○ **Divorced and not married** ○

Widowed and not remarried ○ **Cohabitating (non married)** ○ **Divorce pending** ○

Partnered (specifiy) ○

If married, are you presently living with your spouse? **Yes** ○ **No** ○

If married, years married to present spouse

Please list any children and their ages:

COUNSELING HISTORY

Are you presently receiving other counseling services? **Yes** ○ **No** ○

If yes, please briefly describe:

Have you had any chemical dependency treatment and/or have attended a support group such as A.A., Al-Anon, and the like? Please describe.

Have you received counseling in the past? **Yes** ◯ **No** ◯

If yes, please briefly describe:

What has led you to seek help at this time?

Who do you go to for support (family, friends, faith, or self-help groups)?

How long has this problem persisted?

How severe do you believe this problem is? 1 is just an irritant and 10 is VERY distressing

Under what conditions are your problems usually improved? When do you feel happy, calm and peaceful?

What brings you joy (if different from above)?

Under what conditions are your problems usually worsened?

How did you hear about this clinic, or who referred you?

Your Physicians' Name(s)

Clinic

List any major illnesses and/or operations you've had

List any physical concerns you are presently having: (e.g. high blood pressure, headaches, dizziness, etc.)

Have you had any head traumas? If yes, describe.

When was your last complete physical exam? What were the results?

On average how many hours of sleep do you get daily?

What is your sleep like? (normal, hard to fall asleep, early wakening, fitful, more or less than usual) Please describe.

What are your appetite/eating habits like?

Have you gained/lost over ten pounds in the past year?

Yes ○ **No** ○ **Gained** ○ **Lost** ○

What medications are you taking presently, and for what purpose?

Have you ever been involved with the legal system (child custody, order for protection, DWI, etc)? **Yes** ○ **No** ○

If yes, please explain:

Please complete the following:

1. In the past year, have you felt you ought to cut down on your drinking or drug use? **Yes** ○ **No** ○
2. In the past year, have you had people annoy you by criticizing your dirinking or drug use? **Yes** ○ **No** ○
3. In the past year, have you feld bad or guilty about your drinking or drug use? **Yes** ○ **No** ○
4. In the past year, have you had a drink or used drugs as an eye-opener first thing in the morning to steady your nerves, to get rid of a hangover, or to get the day started? **Yes** ○ **No** ○

Please describe your current use of the following:

Alcohol ____ times per **Day?** ○ **Week?** ○ **Month?** ○ **Year?** ○
How much at a time? ____

Tobacco ____ times per **Day?** ○ **Week?** ○ **Month?** ○ **Year?** ○
How much at a time? ____

Caffeine ____ times per **Day?** ○ **Week?** ○ **Month?** ○ **Year?** ○
How much at a time? ____

Marijuana ____ times per **Day?** ○ **Week?** ○ **Month?** ○ **Year?** ○
How much at a time? ____

Other ____
____ times per **Day?** ○ **Week?** ○ **Month?** ○ **Year?** ○
How much at a time? ____

List any problems you have had because of drinking or drug use (with friends, the law, your money, your job, sex, school, family):

Non-work time spent on social media, computers, screens. Average per day:

Does it impact your relationships? If so, explain.

Trauma and abuse history. Describe any major losses you have had (such as death, disability, divorce, relationship changes):

Please describe any trauma or abuse in your life (such as physical, sexual or emotional abuse, assault, neglect, domestic violence, witnessing the abuse of another, etc.

Physical Abuse	
Sexual Abuse	
Emotional Abuse	
Neglect	
Assault	
Military Related	
Discrimination	
Other	

RELIGIOUS CONCERNS

Check as many as apply to your sense of spirituality.

Not Spiritual ☐	**Seeking** ☐	**Hurt by Church** ☐	**Evangelical** ☐
Skeptical ☐	**Growing** ☐	**I love God** ☐	**Charismatic** ☐
Born Again ☐	**God is unfair** ☐	**New Age** ☐	**Non-traditional** ☐
Afraid of God ☐	**Mad at God** ☐	**God loves me** ☐	**I believe but God feels distant** ☐
Losing my faith ☐	**My faith helps me** ☐	**Abandoned by God** ☐	**God is hard to please** ☐
Other ☐			

What is your present religious affiliation?

Catholic ○ **Jewish** ○ **None, but I believe** ○

Athiest or Agnostic ○

Protestant (specify denomination if any) ○

Other (please specify) ○

How important is religious commitment ot you?

Unimportant **Average Importance** **Extremely Important**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Are you comfortable with counseling from a Christian perspective? **Yes** ○ **No** ○ **Unsure** ○

Comments or questions about this? Please explain:

FAMILY HISTORY

Mother's Age: | **If deceased, how old were you when she died?**

Father's Age: | **If deceased, how old were you when he died?**

If your parents are separated or divorced, how old were you then?

Number of brothers: | **Their ages:**

Number of sisters: | **Their ages:**

I was child number | **In a family of**

Were you adopted or raised with parents other than your natural parents? **Yes** ○ **No** ○

Briefly describe your relationship with your brothers and/or sisters:

Which of the following best describes the family in which you grew up?

Warm and Accepting — **Average** — **Hostile and Fighting**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Which of these describes the way in which your family raised you?

Allowed Independence — **Average** — **Controlling**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Briefly describe your mother or mother substitute:

How much and how did she discipline you?

How did she reward you?

How much time did she spend with you when you were a child? ○ **Much** ○ **Average** ○ **Little**

Your mother's occupation when you were a child?

Stay at home ○ **Worked outside part-time** ○ **Worked outside full-time** ○

How did you get along with your mother as a child? **Poorly** ○ **Average** ○ **Well** ○

How did you get along with your mother now? **Poorly** ○ **Average** ○ **Well** ○

Did your mother have any problems (e.g alcoholism, violence, etc.) which may have affected your childhood development? **Yes** ○ **No** ○

If yes, please describe:

Is there anything unusual about your relationship with your mother? **Yes** ○ **No** ○

If yes, please describe:

Your mother's treatment to you

Poor — **Average** — **Excellent**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Your mother's treatment to your family

Poor — **Average** — **Excellent**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Your mother's treatment to your father

Poor **Average** **Excellent**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Briefly describe your father or father substitute:

How much and how did he discipline you?

How did he reward you?

How much time did he spend with you when you were a child? ○ **Much** ○ **Average** ○ **Little**

Your father's occupation when you were a child?

Stay at home ○ **Worked outside part-time** ○ **Worked outside full-time** ○

How did you get along with your father as a child? **Poorly** ○ **Average** ○ **Well** ○

How did you get along with your father now? **Poorly** ○ **Average** ○ **Well** ○

Did your father have any problems (e.g alcoholism, violence, etc.) which may have affected your childhood development? **Yes** ○ **No** ○

If yes, please describe:

Is there anything unusual about your relationship with your father? **Yes** ○ **No** ○

If yes, please describe:

Your fathers treatment to you

Poor **Average** **Excellent**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Your father's treatment to your family

Poor **Average** **Excellent**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

Your father's treatment to your mother

Poor **Average** **Excellent**

1 ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○

THOUGHTS

Please check how often the following thoughts occur to you:

1. Life is hopeless	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
2. I am lonely	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
3. No one cares about me	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
4. I am a failure	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
5. Most people don't like me	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
6. I want to die	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
7. I am so stupid	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
8. I want to hurt someone	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○
9. I feel joyful	**Never** ○	**Rarely** ○	**Sometimes** ○	**Frequently** ○

10. I feel worthless	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
11. I am so depressed	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
12. God is disapointed in me	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
13. I can't be forgiven	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
14. I can't concentrate	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
15. I can't do anything right	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
16. Why am I so different?	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
17. I am emotionally numb	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
18. I am out of control	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
19. I am going crazy	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
20. People hear my thoughts	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
21. There is "chatter" in my head	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
22. Someone is watching me	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯
23. I have resentful thoughts	**Never** ◯	**Rarely** ◯	**Sometimes** ◯	**Frequently** ◯

Please comment (e.g. examples, frequency, effects on you) about each of the above thoughts which occur frequently

Any other thoughts or beliefs about self that impair your quality of life?

SYMPTOMS

Check the behaviors and symptoms which are a significant impairment in your life.

Aggression	**Fatigue**	**Sexual Difficulties**
Alcohol Issues	**Hallucinations**	**Sick Often**
Anger	**Heart Palpitations**	**Sleeping Problems**
Distressing Dreams	**Antisocial Behavior**	**High Blood Pressure**
Speech Problems	**Anxiety**	**Hopelessness**
Suicidal Thoughts/Plan	**Avoiding People**	**Impulsiveness**
Thoughts Disorganized	**Chest Pain**	**Irritability**
Trembling	**Depression**	**Judgement Errors**
Withdrawing	**Disorientation**	**Loneliness**
Worrying	**Distractibility**	**Memory Impairment**
Dizziness	**Mood Shifts**	**Drug Dependence**
Panic Attacks	**Eating Disorder**	**Phobias/Fears**
Elevated Mood		

Obsessing Thoughts (specify)	
Compulsive Behaviors (examples)	
Other Symptoms (specify)	

Give examples of how each of these symptoms (above) which you consider significant impairments (e.g. socially, emotionally, occupationally, physically, etc.)

What strengths or resources do you have that will help you succeed in counseling? (Examples include commitment, strong family support, intelligence, good social support, church, friends, etc.) And what is your greatest success?

1.
2.
3.
4.
5.

List your five greatest limitations. What is your greatest challenge?

1.
2.
3.
4.
5.

List your main social difficulties.

List your main love and sex difficulties.

List your main difficulties at school or work.

List your main difficulties at home.

List your behaviors which you would like to change.

Additional information you belive would be helpful.

PATIENT HEALTH QUESTIONNAIRE - 9 (PHQ-9)

Patient Name _____ **Date** _____

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several Days	More than 1/2 the days	Nearly Every Day
1. Little interest or pleasure in doing things	0 ○	1 ○	2 ○	3 ○
2. Feeling down, depressed, or hopeless	0 ○	1 ○	2 ○	3 ○
3. Trouble falling or staying asleep, or sleeping too much	0 ○	1 ○	2 ○	3 ○
4. Feeling tired or having little energy	0 ○	1 ○	2 ○	3 ○
5. Poor appetite or overeating	0 ○	1 ○	2 ○	3 ○
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	0 ○	1 ○	2 ○	3 ○
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0 ○	1 ○	2 ○	3 ○
8. Moving or speaking so slowly that other people could have notices? O the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	0 ○	1 ○	2 ○	3 ○
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0 ○	1 ○	2 ○	3 ○
Total				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all ○ **Somewhat** ○ **Very** ○ **Extremely** ○

PHQ9 total score from columns _____

Score	**Symptom Severity**
5-9	Mild Depression
10-14	Moderate Depression
15-19	Moderately Severe Depression
20-27	Severe Depression

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GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Patient Name | **Date** mm-dd-yyyy

Over the last 2 weeks, how often have you been bothered by and of the following problems?

	Not at all	Several Days	More than 1/2 the days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Column total				
Add the score for all columns				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all **Somewhat** **Very** **Extremely**

Key

0-4	Minimal anxiety
5-9	Mild anxiety
10-14	Moderate anxiety
15+	Severe anxiety

Source: Spitzer RL, Kroehke K, Williams JBW, Lowe B. A brief measure for assessing generalized anziety disorder. Arch Inern Med. 2006;166:1092-1097