

Biographical Information-Intake Form

Meredith Kornfeld, MS, MFT

Please fill out this background information as completely as possible. It will help me in our work together. All information is confidential as outlined in the Office Policies form. If you do not wish to answer any question, write "Do not care to answer." Please print or write clearly.

Name: _____ Date: _____

Male/Female/Other (please specify if Other) _____

Date of Birth/Place: _____ Age: _____

Address: _____

Telephone: H: _____ C: _____ email: _____

Emergency Contact (name/phone#/relationship): _____

Referral Source: _____

Occupation (former, if retired, do you enjoy your work? Is there anything stressful about it?)

Presenting Problem (be as specific as you can. When did it start, how is it affecting you...):

How severe is the problem: Mild Moderate Severe Very Severe

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

Please describe any sleeping difficulties: _____

Past/Present Drug/Alcohol Use/Abuse (if you consider this a problem, have you had treatment?) :

Past/Present Eating Disorders (have you had treatment?)

Suicide Attempts/Thoughts:

Previous Therapy History: (estimated dates from most recent, duration, name of therapist, phone number, reason for therapy, was it helpful?):

1)

2)

3).

Please list all current medications:

Past/Present Medical History (major medical issues, surgeries, accidents, illnesses):

Current Medical Doctor (Name, phone #):

Sexual Orientation:

Relationship Status: Married Single Divorced Domestic Partnership
Widowed Separated Not currently in a relationship

Past/Present Significant Other/Spouse: (years together, names, brief description of relationship(s):

Children/Step/Grand: (names, ages, status of your relationship with them):

Parents/Step-Parents (name/ages or year/cause of death, occupation, personality, brief statement about the relationship, past and present):

Father:

Mother:

Step-Parents:

Siblings/Half/Step (name/ages or year/cause of death, brief statement of relationship, past and present):

Childhood (family dynamics, expression of feelings in the family, school, neighborhood, any trauma you feel comfortable putting down, behavioral problems, anything you want me to know):

If Parents Divorced/Remarried (your age, describe how it affected you and the family, with whom did you live?):

Family History of Substance Abuse, Mental Illness, or Violence (including suicide/ suicide attempts, hospitalizations, treatment, etc.):

Family Medical History (describe any illness that runs in your family):

Friendships, Community, and Spirituality (briefly describe the people most important to you, important activities or groups and their frequency, and describe any spiritual life you may have-these all help me to get to know you better).

What gives you the most joy or pleasure in your life:

What are your main worries or fears:

What are your main challenges:

What are your main strengths and skills:

What would you like to accomplish from your time in therapy: