CECILIA MCKAY, JD, LMFT
14751 Plaza Drive, Suite F
Tustin, CA 92780
Tel: (714) 501-5332

BIOGRAPHICAL INFORMATION FORM

Please fill out this biographical background form to help your therapist have a better understand and make their best approach. All information is confidential as outlined in the Office Policy form. Leave blank any answers you wish not to respond to. Please print and bring it with you to your first session.

NAME _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY CONTACT PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

REFERRED BY _____

EMERGENCY CONTACT #1 _____ PHONE _____

EMERGENCY CONTACT #2 _____ PHONE _____

OCCUPATION (FORMER IF RETIRED OR UNEMPLOYED) _____

PRESENTING PROBLEM (WHEN DID IT START, HOW HAS IT AFFECTED YOUR LIFE?)

_____

_____

_____

ESTIMATE SEVERITY OF PRESENTING PROBLEM (CIRCLE ONE)

MILD MODERATE SEVERE VERY SEVERE

RELATIONSHIP STATUS (SINGLE, MARRIED OR DIVORCED)_____

DO YOU LIVE WITH SOMEONE? _____ NAME _____ YEARS _____

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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-CHILDREN/GRAND-CHILDREN (NAMES/AGES & BRIEF STATEMENT ON YOUR RELATIONSHIP WITH THE PERSON)

_____

_____

_____

PARENTS/STEP-PARENTS (NAME/AGE OR YEAR OF DEATH/CAUSE OF DEATH, OCCUPATION, PERSONALITY, HOW DID HE/SHE TREAT YOU? BRIEF STATEMENT ABOUT THE RELATIONSHIP)

FATHER _____

_____

MOTHER _____

_____

SIBLINGS (NAME/AGE OR YEAR OF DEATH/CAUSE OF DEATH & BRIEF STATEMENT ABOUT THE RELATIONSHIP)

_____

_____

_____

MEDICAL DOCTOR/S _____ PHONE _____

MAY DR. GLENN MCCLELLAN FAX, CALL AND COORDINATE YOUR CARE WITH YOUR DR? _____

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PAST/PRESENT MEDICAL CARE (MAJOR MEDICAL PROBLEMS, SURGERIES, ACCIDENTS, FALLS, ILLNESSES)

SPECIFY ALL MEDICATION YOU ARE PRESENTLY TAKING, SPECIFY FOR WHAT CONDITIONS

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, TREATMENTS)

SUICIDE ATTEMPT/S OR VIOLENT BEHAVIOR (DESCRIBE: 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.)

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DO YOU EXERCISE REGULARLY? (HOW OFTEN? WHAT KIND OF ACTIVITIES?)

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)

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, AND HOW IT AFFECTED YOU

FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS, OR VIOLENCE (INCLUDING SUICIDE, DEPRESSION, HOSPITALIZATIONS IN MENTAL INSTITUTIONS, ABUSE, ETC.)

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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?