

**Clear Life Services, LLC**  
**Biographical Information Form – Adult**

**Instructions:** Please fill out this form as completely as possible. Please write “NA” through any questions that do not apply. All information will be kept confidential within legal limits (*see Informed Consent statement for exceptions*).

**Personal History**

1) Name: \_\_\_\_\_ 2) Age: \_\_\_\_\_ 3) Gender: \_\_\_M \_\_\_F

4) Address: \_\_\_\_\_

5) Weight: \_\_\_\_\_ 6) Height: \_\_\_\_\_ 7) Eye color: \_\_\_\_\_ 8) Hair color: \_\_\_\_\_ 9) Race: \_\_\_\_\_

10) Today’s Date: \_\_\_\_\_ 11) Date of Birth: \_\_\_\_\_ 12) Highest Education: \_\_\_\_\_

13) Home Phone: \_\_\_\_\_ 14) Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

15) Marital Status: (check one below) 16) Occupation: \_\_\_\_\_

\_\_\_\_\_ 1) never married \_\_\_\_\_ 5) separated

\_\_\_\_\_ 2) engaged to be married \_\_\_\_\_ 6) divorced and not remarried

\_\_\_\_\_ 3) married for 1<sup>st</sup> time \_\_\_\_\_ 7) widowed and not remarried

\_\_\_\_\_ 4) married 2<sup>nd</sup> time \_\_\_\_\_ 5) other: \_\_\_\_\_

Children’s Names and ages: \_\_\_\_\_

17) If married, are you currently living with your spouse? \_\_\_Y \_\_\_N

18) How many years have you been married? \_\_\_\_\_ When is your anniversary? \_\_\_\_\_

**Counseling History**

19) Are you receiving counseling services at present? \_\_\_No \_\_\_Yes (please describe): \_\_\_\_\_

20) Have you received counseling in the past? \_\_\_No \_\_\_Yes (please describe): \_\_\_\_\_

21) What is (are) the main reason(s) for your visit? \_\_\_\_\_

22) How long has this problem persisted (from #21)? \_\_\_\_\_

23) Under what conditions do your problems get worse? \_\_\_\_\_

24) Under what conditions do your problems improve? \_\_\_\_\_

25) How did you hear about Clear Life Services, LLC? \_\_\_\_\_

## Medical History

26) Name and Address of Physician(s):

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Street & Number

City

State

Zip

27) List any major illnesses and/or operations: \_\_\_\_\_

28) List any present physical conditions (e.g. high blood pressure, headaches, dizziness, etc.): \_\_\_\_\_

29) List any previous physical conditions (e.g. head trauma, seizures, etc.): \_\_\_\_\_

30) Most Recent Physical Exam: \_\_\_\_\_ Results: \_\_\_\_\_

31) On average, how many hours of sleep do you get per night? \_\_\_\_\_

32) Do you have trouble falling asleep at night? \_\_\_No \_\_\_Yes (please describe): \_\_\_\_\_

33) Have you gained/lost over ten pounds in the past year? \_\_\_No \_\_\_Yes (please identify whether gain or loss and whether intentional or not): \_\_\_\_\_

34) Describe your appetite during the past week:

\_\_\_Poor appetite \_\_\_Average appetite \_\_\_Large appetite

35) What medications (and dosages) are being taken at present, and for what purpose? \_\_\_\_\_

## Religious History

36) What is your present religious affiliation (if any):

\_\_\_Catholic \_\_\_Jewish \_\_\_Protestant (specify denomination) \_\_\_\_\_

\_\_\_None, but I believe in God / Higher Power (circle one) \_\_\_Atheist or Agnostic (circle one)

\_\_\_Other (please specify) \_\_\_\_\_

37) How important is religious commitment to you? Unimportant Average Extremely

1 2 3 4 5 6 7

38) Do you desire to have your religious beliefs and values incorporated into the counseling process?

\_\_\_No \_\_\_Unsure \_\_\_Yes (please explain) \_\_\_\_\_

## Family History

39) Mother's age: \_\_\_\_\_ If deceased, how old were you when she died? \_\_\_\_\_

40) Father's age: \_\_\_\_\_ If deceased, how old were you when he died? \_\_\_\_\_

41) How old were you when your parents separated / divorced (circle one): \_\_\_\_\_

- 42) Number of brother(s) \_\_\_\_\_ Ages: \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_
- 43) Number of sister(s) \_\_\_\_\_ Ages: \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_
- 44) Birth Order - I was child number \_\_\_\_\_ in a family of \_\_\_\_\_ children
- 45) Were you adopted or raised w/ parents other than your biological parents? \_\_\_No \_\_\_Yes (please explain):

46) Briefly describe your relationship with your brother(s) and/or sister(s): \_\_\_\_\_

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

Warm/Accepting	Average					Hostile/Fighting
1	2	3	4	5	6	7

48) Which of the following best describes the way in which your family raised you?

Forced Independence	Average					Exerted Complete Control
1	2	3	4	5	6	7

**YOUR MOTHER (Or mother substitute)**

49) Briefly describe your mother: \_\_\_\_\_

50) How did she discipline you? \_\_\_\_\_

51) How did she reward you? \_\_\_\_\_

52) How much time did she spend with you when you were a child? \_\_\_Little \_\_\_Average \_\_\_Much

53) What was your mother's occupation when you were a child? \_\_\_\_\_

\_\_\_Stayed home \_\_\_Worked outside part-time \_\_\_Worked outside full-time

54) How did you get along with your mother when you were a child? \_\_\_Poorly \_\_\_Average \_\_\_Well

55) How do you get along with your mother now? \_\_\_Poorly \_\_\_Average \_\_\_Well

56) Did your mother have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development? \_\_\_No \_\_\_Yes (please explain): \_\_\_\_\_

57) Is there anything special/unusual about your relationship with your mother? \_\_\_No \_\_\_Yes (please explain)

58) Describe overall how your mother treated each of the following people as you were growing up: (circle one)

<u>MOTHER'S TREATMENT OF:</u>	Poor		Average			Excellent	
1) You (personally)	1	2	3	4	5	6	7
2) Your Family	1	2	3	4	5	6	7
3) Your Father	1	2	3	4	5	6	7

**YOUR FATHER** (Or father substitute)

59) Briefly describe your father: \_\_\_\_\_

60) How did he discipline you? \_\_\_\_\_

61) How did he reward you? \_\_\_\_\_

62) How much time did he spend with you when you were a child? \_\_\_Little \_\_\_Average \_\_\_Much

63) What was your father's occupation when you were a child? \_\_\_\_\_

\_\_\_Stayed home \_\_\_Worked outside part-time \_\_\_Worked outside full-time

64) How did you get along with your father when you were a child? \_\_\_Poorly \_\_\_Average \_\_\_Well

65) How do you get along with your father now? \_\_\_Poorly \_\_\_Average \_\_\_Well

66) Did your father have any problems (e.g. alcoholism, violence, etc.) that may have affected your childhood development? \_\_\_No \_\_\_Yes (please explain): \_\_\_\_\_

67) Is there anything special/unusual about your relationship with your father? \_\_\_No \_\_\_Yes (please explain)

68) Describe overall how your father treated each of the following people as you were growing up: (circle one)

<u>FATHER'S TREATMENT OF:</u>	Poor			Average			Excellent		
1) You (personally)	1	2	3	4	5	6	7		
2) Your Family	1	2	3	4	5	6	7		
3) Your Mother	1	2	3	4	5	6	7		

**Thoughts & Behavior History**

69) 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 want to hurt someone \_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Frequently

8) I am so stupid \_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Frequently

9) I am going crazy \_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Frequently

10) I can't concentrate \_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Frequently

11) I am so depressed \_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Frequently

12) God is disappointed in me \_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Frequently

- |                               |             |              |                 |                  |
|-------------------------------|-------------|--------------|-----------------|------------------|
| 13) I can't be forgiven       | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 14) Why am I so different?    | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 15) I can't do anything right | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 16) People hear my thoughts   | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 17) I have no emotions        | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 18) Someone is watching me    | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 19) I hear voices in my head  | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |
| 20) I am out of control       | _____ Never | _____ Rarely | _____ Sometimes | _____ Frequently |

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

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Symptoms

70) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

- |                           |                           |                             |
|---------------------------|---------------------------|-----------------------------|
| _____ aggression          | _____ fatigue             | _____ sexual difficulties   |
| _____ alcohol dependence  | _____ hallucinations      | _____ sick often            |
| _____ anger               | _____ heart palpitations  | _____ sleeping problems     |
| _____ antisocial behavior | _____ high blood pressure | _____ speech problems       |
| _____ anxiety             | _____ hopelessness        | _____ suicidal thoughts     |
| _____ avoiding people     | _____ impulsivity         | _____ thoughts disorganized |
| _____ chest pain          | _____ irritability        | _____ trembling             |
| _____ depression          | _____ judgment errors     | _____ withdrawing           |
| _____ disorientation      | _____ loneliness          | _____ worrying              |
| _____ distractibility     | _____ memory impairment   | _____ other (specify)       |
| _____ dizziness           | _____ mood shifts         | _____                       |
| _____ drug dependence     | _____ panic attacks       | _____                       |
| _____ eating disorder     | _____ phobias/fears       | _____                       |
| _____ elevated mood       | _____ recurring thoughts  | _____                       |

Please give examples of how each of the symptoms that your checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

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71) List your five greatest strengths:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

72) List your five greatest weaknesses:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

73) List your main social difficulties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

74) List your main love and sex difficulties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

75) List your main difficulties at school or work: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

76) List your main difficulties at home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

77) List your behaviors that you would like to change: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

78) Additional information you believe would be helpful: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Thank you for taking the time to complete this information.  
Please feel to contact us if you have any questions or concerns.***