WENTWORTH HEALTH PARTNERS

Behavioral Health - Adult Biographical Information Form

Biographical Information

This information will help us to prepare for your visit and facilitate planning your treatment. If you are hesitant to complete any or all parts of this form, you can discuss this with your behavioral health provider during your initial assessment.

Name: _____ Today's Date: _____
DOB: _____ Age: _____

General Demographic Information:
Please circle: Rent / Own Is your housing stable? Yes / NO Is your housing affordable? Yes / No
Please list all members of your household: _____
_____

Preferred language? Written_____ Spoken_____

Family Information

	Name	DOB	Mental Illness?	Strength of relationship:
Parents				
Siblings				
Children				
Spouse/ Partner				

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Are you currently active in a religious community? Yes / No
Religious Affiliation: _____

Military Involvement? Yes / No
If YES, please specify: Self / Loved one: _____ Branch of military?_____
Past / Current Combat Deployment? Yes / No Combat related diagnosis?_____

Education/Employment:
Did you graduate high school? Yes / No Year graduated: _____
Degree(s) earned/year:_____
Any learning problems, hyperactivity, or behavioral problems in school? _____
_____
_____

Are you currently working? Yes / No If YES, how many hours/week: _____
Current employer: _____ Job Title: _____
Is your job stable? Yes / NO
Is your income enough to meet your basic needs? Yes / No
If NO, are you currently: ☐ Unemployed (looking for work) ☐ Disabled ☐ Out of the workforce ☐ Retired
If you are DISABLED, date of disability: _____ Reason for disability: _____
If you are UNEMPLOYED, please explain: _____
_____

Would you like assistance in finding work or being connected with work related resources? Yes / No

Trauma History
Have you ever been the victim of trauma? (Please circle all that apply)

Physical Abuse Sexual Abuse/molestation Domestic Violence Emotional/verbal Abuse

Any experiences, deaths, or major losses in your life that have been particularly hard?_____
_____
_____
_____
_____

Medical History
Any current medical concerns? _____

Any history of head injury? Yes / NO If Yes, please explain _____

How often do you have a drink containing alcohol?
(0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
(0) no (2) yes, but not in the last year (4) yes, during the last year

Have you used drugs other than those required for medical reasons? Yes / No
If YES, please describe (type, quantity, how often): _____

_____

How much coffee/caffeine do you drink each day: _____ Per week: _____

How would you rate the quality of your sleep? _____ # Hours/night: _____

Prior Psychiatric Treatment

Date	Provider/Agency	Reason

Why are you seeking help at this time? What are your goals for treatment?

_____

_____

_____

_____

_____