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## **BIOGRAPHICAL INFORMATION-INTAKE FORM (6 pages)**

Please fill out this biographical background form as completely as possible. It will help me in our work together. All information is confidential as outlined in the Office Policy form. If you do not desire to answer any question, merely write "do not care to answer." Please print or write clearly and bring it with you to the first session.

**NAME:** \_\_\_\_\_ **M / F** **SOC. SEC #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**PLACE OF BIRTH:** \_\_\_\_\_

**SEXUAL ORIENTATION:** \_\_\_\_\_ **ETHNICITY:** \_\_\_\_\_

**ADDRESS:**

\_\_\_\_\_

**TELEPHONES:** **H:** (\_\_\_\_) \_\_\_\_\_ **W:** (\_\_\_\_) \_\_\_\_\_

**FAX:** (\_\_\_\_) \_\_\_\_\_ **CELL:** (\_\_\_\_) \_\_\_\_\_

**PHONE #(s) WHERE A CONFIDENTIAL MESSAGE CAN BE LEFT:** (\_\_\_\_) \_\_\_\_\_

**ADDRESS TO RECEIVE CONFIDENTIAL MAIL:** \_\_\_\_\_

\_\_\_\_\_

**PERSON AND PHONE # TO CALL IN EMERGENCY:** \_\_\_\_\_

**HIGHEST GRADE/DEGREE:** \_\_\_\_\_ **TYPE OF DEGREE:** \_\_\_\_\_

**REFERRAL SOURCE:** \_\_\_\_\_

**OCCUPATION** (former, if retired): \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE :**(\_\_\_\_) \_\_\_\_\_

**IS THE PRESENT CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF YOUR  
EMPLOYMENT? YES:** \_\_\_\_\_ **NO:** \_\_\_\_\_

**PLEASE LIST ALL PRIOR AND/OR CURRENT LITIGATION(S) WITH OTHER THERAPISTS OR**

**PHYSICIANS (USE REVERSE SIDE IF NECESSARY):** \_\_\_\_\_

\_\_\_\_\_

**PRESENTING PROBLEM** (be as specific as you can: When did it start, how does it affect you...):

\_\_\_\_\_

**Estimate the severity of the above problem:**

Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ Very Severe \_\_\_\_\_

**CURRENT: Marital status: M S W D Live with someone: \_\_\_ Name: \_\_\_\_\_ Yrs: \_\_\_\_\_**

**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/GRAND** (names/ages & brief statement on your relationship with the person)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

**PARENTS/STEP-PARENT** (Name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

**Father:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Mother:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Stepparents** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIBLINGS** (name/age, if dead: age and cause of death & brief statement about the relationship):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**MEDICAL DOCTOR(S)** (name /phone):

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**PAST/PRESENT MEDICAL CARE** (major medical problems, hospitalizations/surgeries, accidents, falls, illness, recent lab results/consultation reports, allergies, date of last physical exam, etc.):

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**Specify all MEDICATION(S) you are presently taking and for what. Please PRINT clearly:**

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**Prescribed By:** \_\_\_\_\_

**May I contact this provider:** ☐ Yes ☐ No **Phone #:** (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**PAST/PRESENT DRUG/ALCOHOL USE/ABUSE** (AA, NA, any other form of treatment, duration, which chemical-first use and last use):

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**Coffee:** (#\_\_\_\_ cups/daily)

**Cigarettes:** (#\_\_\_\_ per day)

**Alcohol:** (#\_\_\_\_ drinks/daily\_\_\_\_ or weekly\_\_\_\_) **Date last drank:** \_\_\_\_\_

**Substances:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Date last used:** \_\_\_\_\_

**SUICIDE ATTEMPT(S)** and/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 and activities of your support systems: school/work life, family, relationships, military, spirituality, etc.):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST/PRESENT PSYCHOTHERAPY** (specify: month, year(s) (beginning—end), estimated # 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):

**1.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2.** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS*

**PAST/PRESENT DIAGNOSES OF MENTAL DISABILITIES/MENTAL ILLNESS** (including psychiatric hospitalizations):

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**DESCRIBE YOUR CHILDHOOD IN GENERAL** (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral problems, abusive/alcoholic parent):

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**IF PARENTS DIVORCED:** Your age at the time: \_\_\_\_\_. Describe how it affected you at the time:

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**FAMILY HISTORY OF CHEMICAL DEPENDENCY, MENTAL ILLNESS, OR VIOLENCE**  
(including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

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**Sexual Concerns (describe any concerns/problems/questions you have related to sex including pain, performance issues, lack of desire/pleasure, compulsiveness/addiction, sexual trauma, relationship issues, etc.):**

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**Please indicate how the following symptoms/problems/complaints are affecting you:**

**1) Little effect   2) Some effect   3) Much effect   4) Significant Effect**

*(Leave blank if no effect)*

_____Eating habits/Appetite: eating more, eating less	_____Spending sprees
_____Weight change; amount _____	_____Rapid Heartbeat
_____Binge/purge	_____Phobia
_____Sleep: Trouble falling asleep;	_____Sweating
_____Trouble staying asleep; Trouble waking up;	_____Trouble breathing
_____Average # hours sleep _____ #Naps _____	_____Flashbacks of traumatic events
_____Decreased energy/Fatigue	_____Nightmares
_____Sexual functioning	_____Racing thoughts
_____Loss of interest in activities	_____Impulse control: difficulty controlling
_____Tearfulness	_____physical behavior
_____Hopelessness/Helplessness	_____Mood changes
_____Decreased attention span	_____Anxious/Nervous

\_\_\_\_ Inattentive/Distractible  
\_\_\_\_ Memory: Long term/short term  
\_\_\_\_ Difficulty planning ahead  
\_\_\_\_ Stealing  
\_\_\_\_ Panic attacks - Frequency \_\_\_\_\_

\_\_\_\_ Worry/Fear  
\_\_\_\_ Hearing Voices  
\_\_\_\_ Seeing things that are not there  
\_\_\_\_ Anger outbursts

Rate how the symptoms/problems/complaints are impacting areas of functioning:

**1) Mild 2) Moderate 3) Severe**

*(Leave blank if no effect)*

\_\_\_\_ Marriage/Relationship  
\_\_\_\_ Work/School  
\_\_\_\_ Family  
\_\_\_\_ Friendships  
\_\_\_\_ Financial situation  
\_\_\_\_ Physical health  
\_\_\_\_ Social interests  
\_\_\_\_ Leisure activities

\_\_\_\_ Clubs/Group memberships  
\_\_\_\_ Legal  
\_\_\_\_ Housing  
\_\_\_\_ Attending to daily living activities (i.e. shower,  
grooming, self-care, etc.)  
\_\_\_\_ Spirituality  
\_\_\_\_ Other: \_\_\_\_\_

**What gives you most joy or pleasure in your life?**

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**What are your main worries and fears:**

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**What do you identify as your strengths:**

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**What do you identify as your weaknesses:**

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**What are your goals for treatment:**

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**What are your most important hopes or dreams:**

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*Please add on the other side of the page or on a separate page any other information you would like me to know about you and your situation*

\_\_\_\_\_  
**PATIENT/CLIENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**