KATHLINE COLVIN, Ph.D. **Pacifica Psychological Services**

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CONFIDENTIAL BACKGROUND INFORMATION

Name:____ Today's Date: _______________

If Consultation/Treatment is for your Child, Child's Name: _______________________________

Home Address: ____

Home Telephone: __________________________ Cell Phone: _________________________

Pager #: __________________________________ Other: _____________________________

Employer: ________________________________ _______Years: _______________________

Address: ____

Business Telephone: ________________________ Occupation: ________________________

Birthdate: _________________________________ Age: ______________________________

Highest Level of Education: ____

Social Security #: __________________________ Driver's License #: ____________________

Religion: __________________________________ Ethnic Background: ___________________

Referred by: ____

Consent to Acknowledge Referral (Date if consent is granted): ___________________________

Signature (if consent is granted): ____

Person to call IN CASE OF EMERGENCY: ____

Business Telephone: ________________________ Home Telephone: ____________________

Cell Phone: ________________________________ Relationship: _______________________

Nearest Relative Not Residing With You: ____

Telephone: ________________________________ Relationship: _______________________

RELATIONSHIP HISTORY:

Marital Status: ______________________________ No. of Years: _______________________

Spouse/Partner's Name: ____

Birthdate: _________________________________ Age: ______________________________

Spouse/Partner's Employer: ____

Spouse/Partner's Employer's Address: ____

Spouse/Partner's Employer's Phone:____

Spouse/Partner's Social Security #: ____________ Spouse/Partner Driver's Lic #: ____________

Children (Names and Ages):____

Step-Children (Name and Ages): ____

Grandchildren (Names and Ages): ____

Parents (Names, Ages or year of death): ____

Step-Parents (Names, Ages or year of death): ____

Siblings (Names and Ages): ____

MEDICAL HISTORY:

Major Illnesses: ____

Chronic Illnesses: ____

Hospitalizations: ____

Accidents: ____

Current Medications: ____

Personal Physician: ____

Physician's Specialty: ____

Physician's Address: ____

Physician's Phone Number: ____

Date of Last Office Visit: ____

Drug and Alcohol Use (Current): ____

Past Drug and Alcohol Use: ____

Addictions: ____

Recovery/Treatment Programs: ____

Eating History: ____

History of Eating Disorders: ____

Treatment Programs: ____

Height: __________Weight: ________ Highest Weight: _________ Lowest Weight: _________

FAMILY HISTORY:

Family Medical History: ____

Family Diagnoses: ____

Treatment: ____

Family History of Alcoholism: ____

Family History of Drug Abuse: ____

Family History of Psychological Problems: ____

Family Suicidal Behaviors: ____

Family History of Violent Behaviors: ____

Other History: ____

PATIENT HISTORY OF PSYCHOTHERAPY AND PSYCHIATRIC TREATMENT:

Present Problem/Symptoms: ____

____

Current Diagnoses:____

Treatment (Type): ____

Physician/Psychotherapist's Name(s): ____

Inclusive Dates of Treatment: ____

Physician's Phone Number: ____

Psychotherapist's Phone Number: ____

Past Problems/Symptoms: ____

Past Diagnoses: ____

Treatment (Type): ____

Physician/Psychotherapist's Name(s): ____

Inclusive Dates of Treatment: ____

Physician's Phone Number: ____

Psychotherapist's Phone Number: ____

SOCIAL, OCCUPATIONAL & FAMILY CONCERNS:

Describe your Social Network: ____

____

Describe your Friendships (Close Friends, Friends at Work, etc.): ___________________

____

How often do you socialize with you friends? ________________________________

____

Are you currently in a romantic relationship? ________________________________

Please describe your relationship, and comment on your satisfaction or dissatisfaction in your relationship: ____

____

Do you talk to others about your personal concerns, and the issues that bring you into therapy?

____

____

Describe your current living situation? Do you live alone, or with others? _______________

____

How do you feel about your work? Describe your satisfactions and dissatisfactions with work:

____

____

Describe hobbies and recreational activities that you enjoy: _______________________

____

CURRENT ISSUES:

Please describe the major concerns that you would like to address in therapy:_____________

____

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