TLC Collaborative Counseling

BIOGRAPHICAL INFORMATION

Welcome. Terry L. Chapman LLC dba TLC Collaborative Counseling looks forward to helping you reach your goals. This biographical background form requests information about you and your needs. Please fill out this form as completely as possible. The questions on the following pages are designed to help your therapist best meet your treatment needs. Information is confidential as outlined in the Agreement form and the HIPAA Notice of Privacy Practices. If the person seeking care is a minor, the parent or guardian should complete this form. If you have any questions, your therapist will be happy to answer them.

Section I - Client Information

CLIENT NAME: _____ DATE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: Home: _____ Cell: _____ Work: _____
FOR ROUTINE MESSAGES: Phone #: _____
FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone #: _____
DATE OF BIRTH: _____ PLACE: _____ AGE: _____
GENDER: ☐ Female ☐ Male ☐ Non-binary/ third gender Prefer to self-describe _____
☐ Prefer not to say
EMPLOYER OR SCHOOL: _____
EMPLOYMENT STATUS: _____ Full Time Student? ☐ Yes ☐ No
HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____
EMERGENCY CONTACT: _____
RELATIONSHIP: _____ PHONE #: _____

Is the client covered by insurance and will they be using their benefits for psychotherapy? ☐ Yes - Go to section II

☐ No - Go to section V

Section II - Insured Information

CLIENT RELATIONSHIP TO INSURED: ☐ Self ☐ Partner ☐ Child ☐ Other

If "Client Relationship to insured" is other than "Self" please complete the following. If client is the insured go directly to section III.

INSURED'S NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ Work: _____
DATE OF BIRTH: _____ SSN: _____

MARITAL STATUS: _____ GENDER: ☐ Female ☐ Male ☐ Non-binary/ third gender
☐ Prefer to self-describe_____ ☐ Prefer not to say
EMPLOYER OR SCHOOL: _____ EMPLOYMENT STATUS: _____

Section III - Insurance Policy Information (Please provide a copy of your insurance card)

INSURANCE COMPANY: _____
BILLING ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
MEMBER #: _____ GROUP #: _____
PREAUTHORIZATION CONTACT: _____
PREAUTHORIZATION PHONE #: _____

Is the patient covered by more than one insurance? ☐ Yes - Please complete Section IV
☐ No - Please skip to Section V

Section IV - Secondary Ins. Policy Information (Please provide a copy of your insurance card)

INSURED'S NAME: _____ DATE OF BIRTH: _____
EMPLOYER OR SCHOOL: _____ EMPLOYMENT STATUS: _____
INSURANCE COMPANY: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
MEMBER #: _____ GROUP #: _____
PREAUTHORIZATION CONTACT: _____
PREAUTHORIZATION PHONE #: _____

Section V - Billing Information
(Complete only if there is no insurance coverage or client is electing to pay for services out-of-pocket.)

Who is responsible for charges for this patient? ☐ Patient - Please skip to section VI
☐ Other - Please complete the following information.
NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE:_____ WORK:_____
Card Holder's Signature: _____
DATE OF BIRTH: _____ SSN: _____
MARITAL STATUS: _____GENDER: ☐ Female ☐ Male ☐ Non-binary/ third gender
☐ Prefer to self-describe_____ ☐ Prefer not to say

EMPLOYER OR SCHOOL: _____ EMPLOYMENT STATUS: _____

Section VI – Referral Source
NAME: _____ RELATIONSHIP: _____
AGENCY OR ORGANIZATION:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

MAY WE CONTACT? ☐ Yes ☐ No

Section VII – Presenting Problem

Please describe your reason(s) for seeking treatment at this time. If there is a particular event which triggered your decision to seek treatment now, please list the event (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

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of your life:

	No effect	Little effect	Some effect	Much effect	Significant effect	Not Applicable
Marriage/Relationship						
Family						
Job/School performance						
Friendships						
Financial situation						
Physical health						
Anxiety level/Nerves						
Mood						
Eating habits						
Sleeping habits						
Alcohol/Drug usage						
Ability to concentrate						
Ability to control your temper						

What are your goals for therapy?

_____

_____

_____

Section VIII – Relationship History

CURRENT RELATIONSHIP STATUS: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Spouse/ Partner's name: _____ Years in current relationship status: _____

PRESENT SPOUSE/PARTNER'S: Education: _____ Occupation: _____
PAST & PRESENT MARRIAGE(S) (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile): _____

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: _____

Step-parents: _____

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

1. _____
2. _____
3. _____
4. _____
5. _____

Please list other persons living in your household, their relationship to you and their age:

Section IX – Medical History

PRIMARY CARE PHYSICIAN: _____ Phone #: _____
PRACTICE OR AGENCY: _____
DATE OF LAST PHYSICAL EXAM: _____ MAY WE CONTACT? ☐ Yes ☐ No

PSYCHIATRIST: _____ Phone #: _____
PRACTICE OR AGENCY: _____
DATE OF LAST VISIT: _____ MAY WE CONTACT? ☐ Yes ☐ No

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness): _____

SPECIFY MEDICATION (this should include OTC, prescribed and/or herbal supplements) you are presently taking. PRINT clearly:

Medication	**Dosage**	**Reason**	**Prescribing Physician**

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (AA, NA, treatments): _____

SUICIDE ATTEMPT(S) or VIOLENT BEHAVIOR (Describe ages, reasons, circumstances, how, etc):

PAST/PRESENT PSYCHOTHERAPY:

1. When _____ Estimated # of sessions_____
Provider _____
Reason_____ Ind/Couple/Family/Group
How helpful?_____ How/Why ended_____

2. When _____ Estimated # of sessions_____
Provider _____
Reason_____ Ind/Couple/Family/Group
How helpful?_____ How/Why ended_____

3. USE OTHER SIDE OF THE PAGE FOR MORE INFORMATION ABOUT PSYCHOTHERAPISTS

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: _____. Describe how it affected you at the time _____

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

Section X – Other Information

FRIENDSHIPS, COMMUNITY, & SPIRITUALITY (Describe quality, frequency, activities, etc.): _____

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION(S), LAWSUIT(S) OR DIVORCE OR CUSTODY DISPUTE(S)? ☐ Yes ☐ No
(If you answer Yes, please explain): _____

Have you ever been arrested? ☐ Yes ☐ No (If yes, please write explanation on back of page.)
Have you ever been convicted of a crime? ? ☐ Yes ☐ No (If yes, please state what crime and provide a brief explanation on back of page.)

What do you consider to be your personal strengths? _____

What are your main worries? _____