

**MADLINE POLONIA, PSY.D., PSY17247
15525 Pomerado Road, Suite B-1
Poway, CA 92064**

Biographical Information – Intake Form

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Office Policy form and the HIPAA Notice of Privacy Practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please write clearly, print a copy and bring it with you to the first session. Many Thanks.

NAME: _____ MALE/FEMALE: _____ DATE: _____

DATE OF BIRTH and PLACE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONES: H: _____ Cell: _____ Work: _____ Fax: _____

FOR ROUTINE MESSAGES: Phone # _____ Email: _____

FOR CONFIDENTIAL MESSAGES: Phone # _____ Email: _____ Text: _____

EMERGENCY CONTACT: NAME AND #: _____

REFERRAL SOURCE: _____

OCCUPATION (former, if retired): _____

PRESENTING PROBLEM (be as specific as you can: when did it start? how does it affect you?
What are your symptoms?):

Estimate the severity of above problem: Mild ____ Moderate ____ Severe ____ Very severe ____

ABUSE HISTORY (physical, sexual, emotional; when? how long?)

DEVELOPMENTAL HISTORY (delays? Full term or premature? Any complications during pregnancy or during birth?) _____

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PSYCHOSOCIAL HISTORY (age of first boyfriend/girlfriend? Age of first intimate experience? Are you currently sexually active?)

EDUCATIONAL HISTORY (Highest degree earned? Type of degree? Did you or anyone in your family have any problems in school?)

RELATIONSHIPS:

CURRENT: Marital status: ____ Live with someone: ____ Name: _____ Years: ____

PAST & PRESENT MARRIAGE/S (names, years together, and 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. _____

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

Father:

Mother: _____

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Stepparents:

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

1. _____
2. _____
3. _____

MEDICAL HISTORY:

DOCTOR (S) (name/phone): _____

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

SPECIFY MEDICATION you are presently taking and for what. Please print clearly:

FAMILY MEDICAL HISTORY (Describe any illness that runs in the family: (e.g., cancer, epilepsy, etc.):

SUBSTANCE USE:

PAST/PRESENT DRUG/ALCOHOL USE/ABUSE (how often do you use? do you use alone or with others? have you been in previous treatment?):

SUICIDE ATTEMPT/S or VIOLENT BEHAVIOR (current or in the past? Age? Reason? Circumstances? Do you have any thoughts about hurting someone else? Do you suffer from any type of mental illness?) _____

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FRIENDSHIPS, COMMUNITY, & SPIRITUALITY:

PAST/PRESENT PSYCHOTHERAPY (specify: month year(s) (beginning—end), estimated # of sessions, name, degree, phone & address, initial reason for therapy, Individual/Couple/Family, medication, brief description of the relationship and how helpful it was, and how/why it ended):

1. _____

2. _____

3. *USE OTHER SIDE OF PAGE TO ADD MORE INFORMATION ABOUT PSYCHOTHERAPISTS, IF NEEDED.*

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

ESTIMATE HOW MANY HOURS/DAY YOU SPEND ONLINE (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: _____ YouTube: _____ Gaming: _____ Texting: _____ Browsing: _____

Work/School: _____ Other: _____

DO YOU FEEL YOUR TECHNOLOGY USE IS BALANCED AND HEALTHY OR COULD IT USE IMPROVEMENT? Please explain:

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

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S, DIVORCE OR CUSTODY DISPUTE/S? (If you answer yes, please explain):

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

What are your main worries and fears?

What are your most important hopes or dreams?

What are your personal strengths?

What are your goals for treatment?

Thank you for completing this very important form!