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Please fill out the 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 complete online or print clearly and bring it with you to the first session.

Today's Date: _____

Referral Source: _____

Name: _____ Gender : _____ Age: _____

Presenting Problem (be as specific as you can: when did it start, how does it affect you.):

Please estimate the severity of above problem:

Mild ____ Moderate ____ Severe ____ Very severe ____

Date and Place of birth: _____

Address: Street: _____ City: _____ State: _____ Zip: _____

Telephone: Home: (____) _____ Cell: (____) _____

Work/Office: (____) _____ Fax: (____) _____

Best phone for routine messages: Home ____ Cell ____ Office ____

Best phone for Confidential messages: Home ____ Cell ____ Office ____

Email: _____@_____. _____

Highest Grade/Degree Completed: _____ Type of Degree: _____

Occupation (former, if retired):

Person & Phone Number to Call in Emergency:

Name: _____ Phone: (____) _____

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:

Stepparents: _____

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

1.

2.

3.

Medical Doctor (S) (name/phone):

Name: _____ Phone (_____) _____

Name: _____ Phone (_____) _____

Name: _____ Phone (_____) _____

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness, etc.):

Specify Medication you are presently taking and for what. PRINT clearly:

Past/Present Drug/Alcohol Use/Abuse (AA, NA, treatments):

Suicide Attempt/s or Violent Behavior (describe: ages, reasons, circumstances, how, etc.)

Family Medical History (Describe any illness that runs in the family: e.g., cancer, epilepsy, etc):

Friendships, Community, & Spirituality:

Past/Present Psychotherapy (specify: month year(s) (beginning—end), estimated no. 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.

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 a 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: _____

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 or 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?

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.