Pathways Behavioral Health, PLLC

4934 Brownsboro Road, Louisville KY 40222, 502-509-1179

Background Information Form

I.
Date______________________

Name_____________________________________ Age________ DOB:_______

Spouse/Partner Name_________________________ Age________ DOB:_______

Home Adress____
Street City/State Zip Code

Telephone (home)________________ (work)_______________ (cell)______________

II.
Current Employment: (Circle)
Full-time Part-time Homemaker Unemployed Student Retired Disability

Employer__________________________ Occupation_________________________

Your Annual Income______________ Combined (self & partner) Income____________

Education Completed___________________________

III.
Referred by__________________________________ Phone ___________________

Relationship to referral____

May I contact referral to acknowledge that you have begun therapy? _____yes ____no

IV.
In case of emergency notify:____
Name Relationship

____________________ ____
Phone Number(s) Address

V.
Marital/Relationship Status: (circle all that apply)

Single (never married)		Significant Other	Cohabitating/Committed
Separated	Divorced	Widowed	Remarried (after divorce)
Remarried (after spouse's death)			

How long have you been married or in your current relationship?______________

Have you and your partner ever separated?_________ If yes, how long?________

Have you ever consulted a lawyer regarding separation or divorce?_____________

VI.
Children (include biological, adopted, foster, step, etc.):

Name	Sex	Age	Type (bio,step,etc.)
______________________________	______	______	____________________
______________________________	______	______	____________________
______________________________	______	______	____________________
______________________________	______	______	____________________

VII.
Siblings: (include biological, adopted, foster, step, etc.)

Name	Sex	Age	Type	Lived with you?
______________________________	________	______	____________	_____________
______________________________	________	______	____________	_____________
______________________________	________	______	____________	_____________

VIII.
Were your parents:

Married/Committed?	Yes	No
Happy Together?	Yes	No
Divorced?	Yes	No
Separated?	Yes	No
Good Parents?	Yes	No

Did either or both of your parents:
Use alcohol excessively? Yes No
Regularly argue or fight? Yes No
Have extramarital affairs? Yes No
Openly display affection with each other? Yes No
Work well together as a pair? Yes No
Have any experience in psychotherapy? Yes No

IX. (Feel free to use the back of sheet to provide further information on any question.)

Do you ever wish you had NOT gotten into a relationship with your current partner?
Frequently Occasionally Rarely Never

If you had your life to live over, do you think you would:
Select the same partner Select a different partner Never get involved with anyone

Do you confide in your mate?
Almost never Rarely In most things In everything

Would you say you are satisfied with your sexual activities with your partner? Yes No
If not, in what way are you dissatisfied?______________________________

X.
Have you ever been in therapy before? Yes No
If yes, briefly describe the reason(s), date(s), and length of treatment______________________
____
____
Was it a positive experience? Yes No
What did you like or dislike about it?______________________________
____

Are you currently having suicidal thoughts? Yes No
Have you ever seriously contemplated suicide? Yes No
Have you ever attempted suicide? Yes No
If yes, please describe briefly:______________________________
____

Do you have any chronic illnesses, medical conditions, or injuries? Yes No
If yes, please describe briefly:______________________________
____

Are you presently taking any medication (including prescription, contraception, herbal, and over the counter medications)? Yes No
If yes, please list:______________________________

What do you enjoy doing in your spare time?____

Are there things that you used to do, or would like to do, but currently don't?_______________
____

How would you describe your spiritual or religious beliefs? ______________________________
____

Briefly describe your reason(s) for seeking therapy at this time: ___________________________
____

What do you wish to accomplish through the process of therapy? __________________________
____

Is there anything else you think would be important for me to know about you or your family?
____
____

Please check any statement or issue below if it relates to your reason for seeking therapy.

1. Finances
2. Children
3. Your parents
4. Partner's parents
5. Sexual relations
6. Alcohol or drugs
7. Occupation of either partner
8. Housework/chores
9. Arguments
10. Different interests
11. Unmet emotional needs
12. Lack of closeness
13. Different backgrounds
14. Lack of time together
15. Jealousy
16. Infidelity
17. Irresponsibility
18. Domineering partner
19. Indecisiveness
20. Health problems
21. Mutual misunderstandings
22. Religious practices
23. Use of leisure time
24. Number or type of friends
25. Nightmares
26. Bedwetting
27. Nervousness
28. Physical abuse
29. Sexual abuse
30. Temper
31. Stress
32. Headaches
33. Loneliness
34. Energy
35. Depression
36. Fears
37. Anxiety
38. Legal matters
39. Sleep disruption
40. Appetite/weight gain or loss
41. Stomach problems
42. Suicidal thoughts
43. Sadness
44. Loss of loved one(s) due to death

Financial Agreement and Consent to Render Services

Today's Date: ___________________

Person(s) responsible for payment: ____
Name

____
Name

- I understand that I am responsible for payment of fees for services on each visit.
- I understand that services provided may not be covered through Health Insurance.
- I understand that it is the client's responsibility to determine if health insurance covers the services provided and will provide reimbursement.
- I authorize the therapist to release any medical information necessary to process an insurance claim.
- Missed appointments (unless cancelled 24 hours in advance) will be billed.
- Upon request I will be provided a statement of all charges.
- I do hereby seek and consent to take part in treatment by Pathways Behavioral Health, PLLC. I agree to take an active role in this process. I understand that no promises have been made to me as to the results of treatment.
- I am aware that I may stop treatment with Pathways Behavioral Health, PLLC at any time. I will still be responsible for paying for the services I have already received.

Fee per session: __________________
Date: __________________________

Signature of client: ____ Date: __________
(Signature of Client's parent or legal guardian if Client is under 18 years of age.)