Jenny Holland, Psy. D.
Psychotherapy

621 Cherry St., Santa Rosa, CA 95401
Phone: 707-479-2946
Email: Hollandpsyd@gmail.com

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 print or write clearly and bring it with you to the first session.

NAME: _____ PREFERRED PRONOUN _____

DATE: _____ DATE OF BIRTH _____ AGE: _____

ADDRESS: _____

TELEPHONES: Home: _____ Cell: _____ Work/Off: _____

FOR ROUTINE MESSAGES:

Phone #_____ Email: _____

TEXT: _____

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

HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____

PERSON & PHONE NO. TO CONTACT IN EMERGENCY: _____

REFERRAL SOURCE: _____

OCCUPATIONS (former, if retired): _____

PRESENTING PROBLEM (be as specific as you can: when did it start, how does it affect you):

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

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:

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. _____

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MEDICAL 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. 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): Was your treatment helpful and effective?

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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/DAYS 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?

If you could change one thing about your life instantly, what would you change?

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Please add, any other information you would like me to know about you and your situation.