

# Tina Bollendorf, MFT

## BIOGRAPHICAL INFORMATION

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. If you do not care to answer any question, merely write, "Do not care to answer." Please print or write clearly.

**NAME:** \_\_\_\_\_ **GENDER:** \_\_\_\_\_ **DATE :** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**TELEPHONE:** *Please indicate if routine messages or confidential messages may be left, or if you prefer that no messages should be left.*

**Home:** \_\_\_\_\_ (Rout., Conf., None) **Cell:** \_\_\_\_\_ (Rout., Conf., None)

**Work/Office:** \_\_\_\_\_ (Rout., Conf., None) **Fax:** \_\_\_\_\_

**PERSON TO CALL IN EMERGENCY:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**HIGHEST GRADE/DEGREE:** \_\_\_\_\_ **OCCUPATION:** \_\_\_\_\_

**CURRENT LIVING SITUATION** (where, with who, how long, quality):

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

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**PAST/PRESENT PSYCHOTHERAPY** (specify: month year/s (beginning—end), estimated no. sessions, name, degree, phone & address, initial reason for therapy, Indiv/Couple/Family, medication, brief description of the relationship and how helpful it was and how/why it ended):

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**FRIENDSHIPS, COMMUNITY SPIRITUALITY & SOCIAL SUPPORT** (Describe quality, frequency, activities, etc.):

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**PAST & PRESENT MARRIAGE/S, CURRENT SIGNIFICANT OTHER** (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

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**CHILDREN/STEP/GRAND** (names/ages & brief statement on your relationship with the person):

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**PARENTS/STEP-PARENTS** (name/age or year of death/cause of death, occupation, personality, how did s/he treat you, brief statement about the relationship):

**Father:** \_\_\_\_\_

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**Mother:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Step-parents:** \_\_\_\_\_

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**IF PARENTS DIVORCED:** Your age at the time: \_\_\_\_\_.

**DESCRIBE HOW IT AFFECTED YOU AT THE TIME:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNIFICANT FAMILY HISTORY** (Please list any events in your family history that might effect you, including divorce, alcoholism, medical illness, mental illness, legal/criminal, violence, suicide, immigration, natural disasters, war, etc.):

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DESCRIBE YOUR CHILDHOOD, IN GENERAL** (Relationships with parents, siblings, others, school, neighborhood, relocations, any school/behavioral/problems, abusive/alcoholic parent):

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

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**DO YOU HAVE ANY MAJOR HEALTH CONCERNS (major medical problems, surgeries, accidents, falls, illness):** \_\_\_\_\_

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**OVERALL, HOW SATISFIED ARE YOU WITH YOUR HEALTH:**

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**MEDICAL DOCTOR/S (name /phone):** \_\_\_\_\_

**MEDICATION (you are presently taking and for what):**

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**ON A SCALE FROM 1 -10 PLEASE RATE YOUR LEVEL OF:**

	Poor	No Issues	Excellent
Nutrition	1	2 3 4 5 6 7 8 9	10
Exercise	1	2 3 4 5 6 7 8 9	10
Social Time/Engagement	1	2 3 4 5 6 7 8 9	10
Recreational Activities	1	2 3 4 5 6 7 8 9	10
Relaxation Time	1	2 3 4 5 6 7 8 9	10

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Sleep 1 2 3 4 5 6 7 8 9 10

**ON A SCALE FROM 1-10 PLEASE RATE YOUR LEVEL OF:**

	No Issue									Severe
Stress	1	2	3	4	5	6	7	8	9	10
Anxiety	1	2	3	4	5	6	7	8	9	10
Depression	1	2	3	4	5	6	7	8	9	10

**PLEASE RATE THE FREQUENCY YOU FEEL THE FOLLOWING:**

I struggle to stay focused.	Never	Sometimes	Often	Always
I am chronically late.	Never	Sometimes	Often	Always
It's hard to maintain a regular schedule.	Never	Sometimes	Often	Always
I have trouble starting and/or finishing things.	Never	Sometimes	Often	Always
It's hard to keep organized.	Never	Sometimes	Often	Always

**PLEASE INDICATE IF YOU FEEL THE FOLLOWING:**

My home life feels chaotic.	Never	Sometimes	Often	Always
My work life feels chaotic.	Never	Sometimes	Often	Always
It's hard to find time for self care.	Never	Sometimes	Often	Always
Major unplanned events keep happening in my life.	Never	Sometimes	Often	Always
I sometimes feel out of control in life.	Never	Sometimes	Often	Always
I feel financially unstable.	Never	Sometimes	Often	Always

**ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? (if Yes, please explain):**

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**WHAT GIVES YOU THE MOST JOY OR PLEASURE IN YOUR LIFE?**

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**WHAT ARE YOUR MAIN WORRIES AND FEARS?**

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**WHAT ARE YOUR HOPES AND DREAMS?**

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**Below or on the other side of the page, please add any other information you would like me to know about you and your situation.**