CHECE PSYCHOLOGICAL, LLC

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STEPHEN D. CHECE, PH.D.
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Independent Forensic, Clinical, Neuropsychological & Psychological Evaluations

Biographical Information Form - Adult

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Personal History

Name: _____ Age:_____ Gender:_____M_____F SS#____-____-_____
Address _____
Street &. Number City State Zip

Weight:_____ Height:_____ Eye color: _____ Hair color:_____ Race: _____
Today's Date: _____ Date of Birth: _____ Years of education: _____
Occupation: _____ Home Phone: _____ Business Phone: _____

Present Marital Status:

_____never married
_____engaged to be married
_____married now for first time
_____married now after first time
_____separated
_____divorced and not remarried
_____widowed and not remarried
_____other (specify)_____

If married, are you living with your spouse at present? Yes _____ No _____
If married, years married to present spouse: _____

Counseling History

Are you receiving counseling services at present? Yes _____ No _____
If Yes, please briefly describe: _____

Have you received counseling in the past? Yes _____ No _____
If Yes, please briefly describe:_____

What is (are) your main reason(s) for this visit?_____

How long has this problem persisted (from previous question)?_____

Under what conditions do your problems usually get worse?_____

Under what conditions are your problems usually improved? _____

How did you hear about this clinic, or who referred you? _____

Medical History

Name and Address of primary care physician:
Physicians Name : _____
Address: _____

List any major illnesses and/or operations you have had: _____
_____

List any physical concerns you are having at present (e.g. high blood pressure, headaches, dizziness, etc): _____
_____

List any other physical concerns you have experienced in the past: _____
_____
_____

When was your most recent complete physical exam? _____
Results of physical exam: _____
_____

On average, how many hours of sleep do you get daily?_____
Do you have trouble falling asleep at night?: _____Yes ____No If yes, describe: _____
_____

Have you gained or lost over ten pounds in the past? ___Yes _____No _____gained ____ lost
If Yes, was the gain/loss on purpose? ____Yes ___No

Describe your appetite (during the past week):
_____ poor appetite ____ average appetite _____ large appetite

What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Religious Concerns

What is your present religious affiliation?
_____ 1. Catholic
_____ 2. Jewish
_____ 3. Protestant (specify denomination):_____
_____ 4. None, but I believe in God
_____ 5. Atheist or agnostic
_____ 6. Other (please specify): _____

How important is religious commitment to you?:

			Average			Extremely
Unimportant			Importance			Important
1	2	3	4	5	6	7

Do you desire to have your religious beliefs and values incorporated into the counseling process?
_____Yes _____No ___ Not sure If Yes, explain:_____
_____

Family History

Mother's age:_____ If deceased, how old were you when she died? _____
Father's age:_____ If deceased, how old were you when he died? _____
If your parents are separated or divorced, how old were you then? _____
Number of brother(s):_____ Their ages _____ _____ _____ _____ _____ _____ _____
Number of sister(s): _____ Their ages _____ _____ _____ _____ _____ _____ _____
I was child number _____ in a family of _____ children.
Were you adopted or raised with parents other than your natural parents? _____Yes _____No
Briefly describe your relationship with your brothers and/or sisters.:_____

_____

_____

Which of the following best describes the way in which you grew up?

Warm & Accepting			Average			Hostile & Fighting
1	2	3	4	5	6	7

Which of the following best describes the way in which your family raised you?

Allowed me to be very independent			Average			Attempted to Control me
1	2	3	4	5	6	7

YOUR MOTHER (or mother substitute)
Briefly describe your mother:_____

_____

How did she discipline you?_____

_____

How did she reward you?_____

_____

How much time did she spend with you when you were a child?_____
_____ much _____ average _____ little

Your mother's occupation when you were a child: _____
_____ stayed home _____ worked outside part-time _____ worked outside full-time

How did you get along with your mother when you were a child?
_____ poorly _____ average _____ well

How do you get along with your mother now?
_____ poorly _____ average _____ well

Did your mother have any problems (e.g. alcoholism, violence, etc) that may have affected your childhood development? _____Yes _____No
If Yes, please explain: _____

Is there anything unusual about your relationship with your mother? _____Yes _____No
If Yes, please describe: _____

_____

Describe overall how your mother treated the following people as you were growing up:
(Circle one answer for each)

YOUR MOTHER'S TREATMENT OF:	Poor			Average			Excellent
1. YOU	1	2	3	4	5	6	7
2. YOUR FAMILY	1	2	3	4	5	6	7
3. YOUR FATHER	1	2	3	4	5	6	7

YOUR FATHER (or father substitute)

Briefly describe your father:_____

_____

How did he discipline you:_____

_____

How did he reward you: _____

_____

How much time did he spend with you when you were a child: _____

_____ much _____ average _____ little

Your father's occupation when you were a child: _____

_____ stayed home _____ worked outside part-time _____ worked outside full-time

How did you get along with your father when you were a child?:

_____ poorly _____ average _____ well

How do you get along with your father now?:

_____ poorly _____ average _____ well

Did your father have any problems (e.g. alcoholism, violence, etc) that may have affected your childhood development?: _____Yes _____No

If Yes, please explain: _____

Is there anything unusual about your relationship with your father?: _____Yes _____No

If Yes, please describe: _____

_____

Describe overall how your father treated the following people as you were growing up:
(Circle one answer for each)

YOUR FATHER'S TREATMENT OF:	Poor			Average			Excellent
1. YOU	1	2	3	4	5	6	7
2. YOUR FAMILY	1	2	3	4	5	6	7
3. YOUR MOTHER	1	2	3	4	5	6	7

Use this space for any issues related to your relationship with your mother or father that you feel needs more description:_____

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

1.	Life is hopeless.	___ Never	___ Rarely	___ Sometimes	___ Frequently
2.	I am lonely.	___ Never	___ Rarely	___ Sometimes	___ Frequently
3.	No one cares about me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
4.	I am a failure.	___ Never	___ Rarely	___ Sometimes	___ Frequently
5.	Most people don't like me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
6.	I want to die.	___ Never	___ Rarely	___ Sometimes	___ Frequently
7.	I want to hurt someone.	___ Never	___ Rarely	___ Sometimes	___ Frequently
8.	I am so stupid.	___ Never	___ Rarely	___ Sometimes	___ Frequently
9.	I am going crazy.	___ Never	___ Rarely	___ Sometimes	___ Frequently
10.	I can't concentrate.	___ Never	___ Rarely	___ Sometimes	___ Frequently
11.	I am so depressed.	___ Never	___ Rarely	___ Sometimes	___ Frequently
12.	God is disappointed in me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
13.	I can't be forgiven.	___ Never	___ Rarely	___ Sometimes	___ Frequently
14.	Why am I so different?	___ Never	___ Rarely	___ Sometimes	___ Frequently
15.	I can't do anything right.	___ Never	___ Rarely	___ Sometimes	___ Frequently
16.	People hear my thoughts.	___ Never	___ Rarely	___ Sometimes	___ Frequently
17.	I have no emotions.	___ Never	___ Rarely	___ Sometimes	___ Frequently
18.	Someone is watching me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
19.	I hear voices in my head.	___ Never	___ Rarely	___ Sometimes	___ Frequently
20.	I am out of control.	___ Never	___ Rarely	___ Sometimes	___ Frequently

Please comment (e.g. examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

Symptoms

Check the behaviors and symptoms that occur to you more often than you would like them to take place:

___aggression
___alcohol dependence
___anger
___antisocial behavior
___anxiety
___avoiding people
___chest pain
___depression
___disorientation
___distractibility
___dizziness
___drug dependence
___eating disorder
___elevated mood
___fatigue
___hallucinations
___heart palpitations
___high blood pressure
___hopelessness
___impulsivity
___irritability
___judgment errors
___loneliness
___memory impairment
___mood shifts
___panic attacks
___phobias/fears
___recurring thoughts
___sexual difficulties
___sick often
___sleeping problems
___speech problems
___suicidal thoughts
___thoughts disorganized
___trembling
___withdrawing
___worrying
___other (specify)
_____
_____
_____
_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (e.g. socially, emotionally, occupationally, physically, etc), Use the back of this sheet if necessary.

List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

List your five greatest weaknesses:

1) _____
2) _____
3) _____
4) _____
5) _____

List your main social difficulties: _____

List your main love and sex difficulties: _____

List your main social difficulties at school and work: _____

List your main difficulties at home: _____

List your behaviors that you would like to change: _____

Additional information you believe would be helpful: _____

PLEASE RETURN THIS AND OTHER ASSESSMENT MATERIALS TO THIS OFFICE AT LEAST TWO DAYS BEFORE YOUR NEXT APPOINTMENT

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CLIENT RIGHTS FORM

1. I understand that I have the right to decide not to enter therapy (although depending on my situation there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue. Initials:_____

2. I understand that I have the right to a safe environment during therapy, free from physical, sexual and emotional abuse. Initials: _____

3. I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress.
   Initials: _____

4. I understand that I have the right to information about the professional capabilities and limitations of any clinicians) involved in my therapy, including their certification/licensure, education and training, experience, specialization, and supervision. I have the right to be treated only by persons who are trained and qualified to provide the treatment I receive. Initials: _____

5. I understand that I have the right to written information about fees, payment methods, co-payments, length and duration of sessions and treatment.
   Initials: _____

6. I understand that my confidentiality will be protected, and information regarding my treatment will not be disclosed to any person or agency without my written permission except under circumstances where the law requires such information to be disclosed. I understand that I have the right to know the limits of confidentiality, the situations in which the therapist or agency is legally required to disclose information about my case to outside agencies, and the types of information which *must* be disclosed.
   Initials: _____

7. I understand that I have the right to know if my therapist will discuss my case with supervisors or peers. I understand that no portion of my therapy may be recorded in audio or video form without my informed written consent, and that if I consent to have any portion of my therapy recorded I have the right to know who will see or hear the recording(s), for what purpose(s) the recording(s) will be used, and when and how the recording(s) will be erased or destroyed. Initials:_____

8. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status. Initials: _____

9. I understand that I have the right to request the release of my clinical information to any agency or person I choose. Initials: _____

X _____

Signature of Client / Responsible Party /Parent or Guardian acting on Client's behalf Date

Printed Name: _____

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CONSENT FOR TREATMENT

1. I have been fully informed of my rights as a client of this office, the extent and limits of confidentiality in therapy, and the goals associated with therapy. With that knowledge, I request and consent to receive therapy from Stephen D. Chece, Ph.D..

   Initials:_____

2. I understand that Stephen D. Chece, PhD. may not disclose information about my therapy to anyone outside this agency without my written consent, except as required by law to comply with a court order, to prevent suicide/self-harm or harm to others, or to stop or prevent abuse of a child, senior, or disabled person. However, I also understand that my participation in treatment may require my written consent to allow Stephen D. Chece, PhD. to provide some information about my therapy to a referring agency and/or an insurance company or other payor, and that if this is the case, the form provided for my written consent for this disclosure will state what specific types of information will be disclosed.

   Initials: _____

_____

_____

_____

_____

_____

_____

_____

X _____
Signature of Client / Responsible Party /Parent or Guardian acting on Client's behalf Date

Printed Name: _____

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CONTRACT FOR SAFETY

I _____ agree to speak to or notify staff or an adult if ever I feel that I am a danger to myself or to others. This includes but is not limited to suicidal/homicidal thoughts, gestures, and hearing voices, seeing things that other people think aren't there, an urge to run away, an urge to hit someone, use an illicit substance, etc. I understand that this contract is to help ensure my safety and the safety of those around me.

Name: _____ Date: _____

Witness: _____ Date: _____

Parent: _____ Date: _____

Parent: _____ Date: _____

Therapist: _____ Date: _____

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RELEASE OF INFORMATION

I, _____ hereby authorize the release and disclosure of the following
(Name of Client or Parent/Guardian)
clinical and/or therapeutic records for the following purpose(s):

☐ Authorization to release information regarding counseling, therapy care and treatment.

☐ Authorization to release information held under the Drug Office and Treatment Act of 1972 (pL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.

☐ Authorization to release information related to Human Immunodeficiency Virus (HlV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release authorized information between Dr. Chece and: _____
_____
_____
_____

__ Specific information to be released (Clients initials to approve release):
__ Assessments and evaluations __ Psychosocial history
__ Continued care and treatment __ Discharge summary

Correspondence (specify): _____
Other (specify): _____
Purpose (s) for which information is to be released:
_____
_____
_____

__ Revocation/Expiration: This Release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a date stated here, _____, this Release of Information will automatically expire after a period of 180 days from the date signed. I have the right to receive a copy of this Release of Information upon my request.

Client/Guardian's Name: _____Signature: _____Date _____

Therapist Name: _____Signature: _____Date:_____