Michael G. Mruz, LCSW, PC
ACSW, MSW
14 Harwood CT, Ste 301
Scarsdale, NY 10583
(914) 722 4151

Adult Biography

Please provide the following information for your records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Please print and complete this form and bring it with you to your first session or allow yourself 15 minutes prior to your appointment to complete the form in the office.

PERSONAL HISTORY

1) Name: _____2) Today's Date:_____

3) Age: ____ 4) Date of Birth_____5) Social Security #: _____ 6) Gender: ☐ F ☐ M

7) Address: _____

Street Number City State Zip

8) Home Phone: ( ) _____ - _____ May I leave a message? ☐ Yes ☐ No

a) Cell Phone: ( ) _____ - _____ May I leave a message? ☐ Yes ☐ No

b) Business Phone: ( ) _____ - _____ May I leave a message? ☐ Yes ☐ No

c) E-mail:_____ May I e-mail you? ☐ Yes ☐ No

d) May I e-mail you information about my practice and other relevant health information? ☐ Yes ☐ No

**Please be aware that e-mail might not be confidential.

9) Weight: _____ 10) Height: _____ 11) Eye Color: _____12) Hair Color: _____ 13) Race:_____

14) Years of Education: ____ 15) Occupational Information: Are you currently employed? ☐ Yes ☐ No

a)If yes, who is your current employer/position? _____

Are you happy at your current position? ☐ Yes ☐ No

b) Please list any work-related stressors, if any:_____

(You may use the back of this sheet if necessary)

16) Present Marital Status:

_____ 1) Never Married

_____ 2) Engaged to be married

_____ 3) Married now for the first time

_____ 4) Married now after first time

_____ 5) Separated

_____ 6) divorced and now remarried

_____ 7) widowed and not remarried

_____ 8) Other (specify) _____

17) If married, are you presently living with your spouse? ☐ Yes ☐ No

18) If married, years married to present spouse: _____

19) Are you currently in a romantic relationship? ☐ Yes ☐ No

If yes, how long have you been in this relationship? _____

On a scale from 1-10 (10 being **very good**) how would you rate the quality on your current relationship or marriage? ____

COUNSELING HISTORY

20) Are you presently receiving counseling services? ☐ Yes ☐ No
If yes, please briefly describe: _____

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

_____

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

_____

_____

23) How long has this problem persisted (from #22) _____

24) Under what conditions do your problems usually get worse? _____

_____

_____

25) Under what conditions do your problems usually improved? _____

_____

26) How did you hear about Michael Mruz or who referred you?_____
May this therapist thank the professional who referred you? ☐ Yes ☐ No

MEDICAL HISTORY

27) Name and address of your primary physician:
Physician's Name:_____ Address: _____

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

_____

29) List any physical conditions or concerns you are presently having (e.g. high blood pressure, ALLERGIES, asthma, headaches etc). _____

_____

a) How is your physical health at present? Please Circle:

○ Poor ○ Unsatisfactory ○ Satisfactory ○ Good ○ Very Good

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

_____

31) When was your last physical exam? _____a)Results of physical exam:_____

32) On average how many hours of sleep do you get daily? _____

33) Do you have trouble falling asleep at night? ☐ Yes ☐ No If yes, describe _____

_____

a) Do you feel you get too little sleep? ☐ Yes ☐ No If yes, describe _____

b) Do you feel you get too much sleep? ☐ Yes ☐ No If yes, describe _____

c) Do you feel you have a poor quality of sleep? ☐ Yes ☐ No If yes, describe_____

_____

d) Do you have disturbing dreams? ☐ Yes ☐ No If yes, describe_____

_____

e) Other concerns about sleep? Describe _____

34) Have you gained or lost over ten pounds in the last two months? ☐ Yes ○ No Gained_____ Lost_____

If Yes, was the gain/loss on purpose? ☐ Yes ☐ No

35) Describe your appetite (during the past week): Poor Appetite ____ Average Appetite____ High Appetite____

MEDICAL HISTORY (continued)

36) What medications (and dosages) are you taking presently, and for what purpose? Including psychiatric medication

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Medication	Purpose

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a) If no current medications, have you been previously prescribed psychiatric medication? ☐Yes ☐No
If yes, please
list:

Medication	Purpose
_____	_____
_____	_____
_____	_____

FAMILY MENTAL HEALTH HISTORY

37) Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty			**Family Member**
Depression	Yes	No	_____
Bipolar Disorder	Yes	No	_____
Anxiety Disorders	Yes	No	_____
Panic Attacks	Yes	No	_____
Schizophrenia	Yes	No	_____
Alcohol/Substance Abuse	Yes	No	_____
Eating Disorder	Yes	No	_____
Learning Disabilities	Yes	No	_____
Trauma History	Yes	No	_____
Suicide Attempts	Yes	No	_____

RELIGIOUS CONCERNS

38) What is your present religious affiliation? (Optional)

____ 1) Catholic
____ 2) Jewish
____ 3) Protestant (Specify denomination if any) _____
____ 4) None, but I believe in God
____ 5) Atheist or Agnostic
____ 6) Other (please specify) _____

39) How important is religious commitment to you?

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

40) Do you desire having your religious beliefs and value incorporated into the counseling process? ☐ Yes ☐ No
If yes, please explain: _____
_____
_____

FAMILY HISTORY

41) Mother's age: _____ If deceased, how old were you when she died?: _____
42) Father's age: _____ If deceased, how old were you when he died?: _____
43) Number of brother(s) _____ Their Ages _____ _____ _____ _____
44) Number of sister(s) _____ Their Ages _____ _____ _____ _____
45) I was child number ____ in a family of ____ children.
46) Were you adopted or raised with parents other than your natural parents? ☐ Yes ☐ No
47) Briefly describe your relationship with your brothers and/or sisters: _____
_____
48) Which of the following best describes the family in which you grew up?

WARM & ACCEPTING				AVERAGE			HOSTILE & FIGHTING	
1	2	3	4	5	6	7	8	9

49) Which of these describes the way your family raised you?

ALLOWED ME TO BE VERY INDEPENDENT				AVERAGE			ATTEMPTED TO CONTROL ME	
1	2	3	4	5	6	7	8	9

YOUR MOTHER (or mother substitute)
50) Briefly describe your mother: _____
51) How did she discipline you? _____
52) How did she reward you? _____
53) How much time did she spend with you when you were a child? ___much ___average ___well
54) Your mother's occupation when you were a child: _____
____ stayed at home ____ worked outside part-time _____ worked outside full-time
55) How did you get along with your mother when you were a child? ____ poorly ____average ____well
56) How do you get along with your mother now? ____ poorly ____average ____well
57) Did your mother have any problems (e.g. alcoholism, violence, etc.) which may have affected your childhood development? ☐ Yes ☐ No If yes, please describe:_____
58) Is there anything unusual about your relationship with your mother? ☐ Yes ☐ No If yes, please describe:
_____
59) Describe overall how your mother treated the following people as you were growing up: (Circle one answer for each)

YOUR MOTHER'S TREATMENT TO:	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)
60) Briefly describe your father:_____
61) How did he discipline you?: _____
62) How did he reward you? _____
63) How much time did he spend with you when you were a child? ___much ___average ___well
64) Your father's occupation when you were a child: _____
____ stayed at home ____ worked outside part-time _____ worked outside full-time
65) How did you get along with your father when you were a child? ____ poorly ____average ____well
66) How do you get along with your father now? ____ poorly ____average ____well
67) Did your father have any problems (e.g. alcoholism, violence, etc.) which may have affected your childhood development? ☐ Yes ☐ No If yes, describe: _____
68) Is there anything unusual about your relationship with your father? ☐ Yes ☐ No If yes, please describe:
_____
69) Describe overall how your father treated the following people as you were growing up:(Circle one answer for each)

YOUR FATHER'S TREATMENT TO:	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

THOUGHTS AND BEHAVIORS

70) Have you ever experienced:(Please Circle)

Extreme depressed mood Yes No

Wild mood swings	Yes	No
Rapid speech	Yes	No
Extreme Anxiety	Yes	No
Panic Attacks	Yes	No
Phobias	Yes	No
Sleep Disturbances	Yes	No
Hallucinations	Yes	No
Unexplained losses of time	Yes	No
Unexplained memory lapses	Yes	No
Alcohol/Substance Abuse	Yes	No
Frequent Body Complaints	Yes	No
Eating disorder	Yes	No
Body image problems	Yes	No
Repetitive thoughts (e.g., Obsessions)	Yes	No
Repetitive Behaviors (e.g., Frequent Checking, Hand-Washing)	Yes	No
Homicidal Thoughts	Yes	No
Suicide Attempt	Yes	No

71) 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 thoughts which you checked **frequently** or are a concern to you. Use the back of this sheet if necessary.

SYMPTOMS

72) Check the behaviors and the symptoms which 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
____ 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 these which you checked impair your ability to function (e.g., socially, emotionally, occupationally, physically, etc.). Use the back of the sheet if necessary.

73) In the last year, have you experienced any significant life changes or stressors?

☐ Yes ☐ No If Yes, please describe _____

74) How often do you engage in recreational drug use? ◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Never

75) Do you regularly use alcohol? ☐ Yes ☐ No

a) In a typical month, how often do you have 4 or more drinks in a 24-hour period? _____

SYMPTOMS (continued)

76) Have you had suicidal thoughts in the past month? ____ Frequently ____ Sometimes ____ Rarely ____ Never
77) Have you had them in the past? ☐ Yes ☐ No If yes, briefly describe: _____

_____

Have you had any Psychiatric Hospitalizations in the past? ☐ Yes ☐ No

If yes, dates and length of stay:_____

_____

78) List your four greatest strengths:
1)_____
2)_____
3)_____
4)_____

79) List your four greatest weaknesses:
1)_____
2)_____
3)_____
4)_____

80) List your main social difficulties: _____
_____
_____

81) List your main love and sex difficulties: _____
_____

82) List your main difficulties at school or work: _____
_____
_____

83) List your main difficulties at home: _____
_____

_____

84) List the behaviors which you would like to change: _____
_____
_____
_____
_____
_____
_____

85) Additional information you believe would be helpful: _____
_____
_____
_____
_____
_____
_____
_____
_____