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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 Memorandum of Understanding 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 email it to me at estellefineberg@gmail.com or fax it to 1-954-463-1370. You can also bring it to me once in person sessions become possible.

DATE: _____ NAME: _____ MALE/FEMALE: _____
DATE OF BIRTH/PLACE: _____ AGE: _____
ADDRESS: _____
City: _____ State: _____ Zip: _____
TELEPHONE: H: _____ Cell: _____ W/Off: _____ FAX: _____
FOR ROUTINE MESSAGES: Phone # _____ E-mail: _____
FOR CONFIDENTIAL/PRIVATE MESSAGES: Phone # _____ E-mail: _____
HIGHEST GRADE/DEGREE: _____ TYPE OF DEGREE: _____
Occupation: _____

In case of emergency (name, relationship, phone):

1. _____
2. _____

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

Estimate the severity of above problem: Mild-Moderate-Severe-Very severe

CURRENT Partner: _____ Years: _____

PARTNER's: Education: _____ Occupation: _____

Nature of your relationship:

PAST Partners (years together, names & statement about the nature of the relationship/s, i.e., friendly, distant, physically/emotionally abusive, loving, hostile):

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

1.

2.

3.

4.

5.

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

Father:

Mother:

Stepparents:

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

1.

2.

3.

4.

5.

MEDICAL DOCTOR/S (name /phone):

PAST/PRESENT MEDICAL CARE (major medical problems, surgeries, accidents, falls, illness):

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: cancer, epilepsy, etc.):

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

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

Name: _____ City/State: _____

Beg Date: _____ End Date: _____ Number of Sessions: _____

Reason for therapy: _____

Reason Therapy Ended: _____

Name: _____ City/State: _____
Beg Date: _____ End Date: _____ Number of Sessions: _____
Reason for therapy: _____

Reason Therapy Ended: _____

Name: _____ City/State: _____
Beg Date: _____ End Date: _____ Number of Sessions: _____
Reason for therapy: _____

Reason Therapy Ended: _____

On a separate sheet of paper, please write the answers to the following questions. Please be as thorough as you can with each question.

Family of Origin (Include significant memories, favorite activities, etc.)

Describe your mother and father (both strengths and weaknesses).

How did your parents show affection to each other and their children?

Describe your parent's marital history.

Describe your parent's parenting philosophy.

Describe your parent's means of motivation/discipline.

Describe the communication style of your family of origin.

How did your parent's handle disagreements and conflicts?

How many siblings do you have and what role did each sibling play in family dynamics?

Do you see any family patterns being repeated in your current family or in your sibling's current families?

Describe any changes in your family of origin, including moves, job changes, significant events, deaths, separations from parents, divorce, major illness, or injuries.

Describe your early childhood including any illnesses, hospitalizations, injuries, & separation from parents.

Current Family:

Describe your current marriage/relationship (include both strengths and weaknesses).

Write a brief description of any previous marriage(s).

Describe your parenting philosophy.

Describe your means of motivation/discipline.

Describe any differences of parenting styles.

Describe your communication styles.

How are decisions made?

Describe any current significant medical problems.

List your children and give a brief description of each child.

What concerns do you have with any other family member?

Describe the family's support system.

Describe your family's involvement with outside activities.

How large of a role (if any) does religion play in your family?

Describe your family's lifestyle.

ARE YOU INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION,
LAWSUITS 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 goals for therapy?

INFORMED CONSENT:

Please provide the information requested below. Your signature will indicate that you understand and accept the information contained in the four-page document "Informed Consent Information".

Printed name: _____

Date of Birth: _____

Social Security Number: _____ - _____ - _____

Address: _____

City _____ State _____ Zip _____

Email Address: _____ Ok to Email? _____

Home phone: _____ OK to leave message (Y/N)? _____

Work phone: _____ OK to leave message (Y/N)? _____

Who referred you to this practice? _____

May I thank your referral source (Y/N)? _____

Will you want receipts to file for insurance reimbursement (Y/N)? _____

This acknowledges that I have read the HIPPA Privacy Form and may request a copy for my files.

Signature: _____

Date: _____