

The purpose of this questionnaire is to obtain a comprehensive picture of your background. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. If more space is needed, please feel free to use additional pages.

It is understandable that you might be concerned about what happens to this information because much or all of it is highly personal. Case records are strictly confidential. No one is permitted to see your case records without your written consent or a court order.

Date:

Name:

Address:

City:

State:

Zip Code:

Telephone: Home:

Work:

Cell:

Is it ok to leave messages at all of these numbers? _____ If not, please specify:

Social Security Number:

Date of Birth:

Marital status (circle answer)

Single, Engaged, Married, Remarried, Separated, Divorced, Widowed

Please give details of any previous marriage(s):

With whom are you now living? (List people, their ages, and your relationship with them)

CLINICAL DATA

Please state in your own words the nature of your main problem(s) and their duration.

Please give a brief account of the history and development of your complaints from onset to present.

Why are you presenting for therapy at this point (as opposed to the onset of your issues)?

Whom have you previously consulted about your present problem(s)?

Was the consultation(s) helpful with your prior therapist(s)? Why or why not?

What did you like/dislike about your previous therapist's style?

Have you ever been hospitalized for psychological/psychiatric problems?

If yes, when and where?

Have you ever attempted suicide?

On the scale below, please estimate the severity of your problem(s).

Mildly upsetting Moderately upsetting Very upsetting Extremely severe Totally incapacitating

Who is most affected by your problem(s) and why?

When are your problem(s) less severe?

When are your problem(s) more severe?

What have you tried in an attempt to alleviate your problem(s)?

How does your problem(s) interfere with work/school, social life, close relationships?

Why do you think you have your problem(s)?

How will we know when we're finished with therapy?

What would be different if your presenting problem(s) didn't exist?

How long do you think your therapy should last and why?

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven modalities of Behaviors, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships, and Biological Factors.

PHYSICAL SENSATIONS

Circle any of the following conditions that often apply to you: (please indicate if it's only during high anxiety)

Headaches	Dizziness	Fainting spells	Memory problem
Stomach trouble	No Appetite	Fatigue	Nausea
Sleep problems	Nightmares	Bowel disturbance	Flushes
Tension	Abdominal pain	Sexual disturbance	Hear things
Feel panicky	Tremors	Depressed	Back pain
Unable to relax	Menstrual difficulties	Palpitations	Twitches
Muscle spasms	Tingling	Numbness	Tics
Skin problems	Dry mouth	Chest pain	Rapid heart beat
Blackouts	Excessive sweating	Visual disturbances	Hearing problems
Don't like to be touched	Others: _____		

IMAGES

Circle any of the following that apply to you:

Being happy	Being talked about	Being trapped	Being hurt
Being aggressive	Being laughed at	Not coping	Being helpless
Being promiscuous	Succeeding	Hurting others	Losing control
Being in charge	Being followed	Failing	Others: _____

I have:

Pleasant sexual images	Seduction images	Unpleasant childhood images
Images of being loved	Negative body image	Unpleasant sexual images
Lonely images	Others: _____	

Describe a very pleasant image, mental picture, or fantasy:

Describe a very unpleasant image, mental picture, or fantasy:

Describe your image of a completely "safe place":

Describe any persistent or disturbing images that interfere with your daily functioning:

How often do you have nightmares?

THOUGHTS

Circle any of the following words/phrases that you might use to describe yourself:

Worthless	Useless	A "Nobody"	Life is empty
Inadequate	Stupid	Incompetent	Naïve
Guilty	Evil	Sympathetic	Intelligent
Morally wrong	Horrible thoughts	Hostile	Agitated
Full of Hate	Anxious	Aggressive	Cowardly
Unassertive	Panicky	Ugly	Unattractive
Deformed	Repulsive	Depressed	Misunderstood
Lonely	Unloved/Unlovable	Bored	Restless
Confused	Unconfident	In conflict	Full of regrets
Confident	Worthwhile	Untrustworthy	Dishonest
Ambitious	Sensitive	Loyal	Crazy
Considerate	Deviant	Honest	Thoughts are racing in your head
Attractive	Suicidal ideas	Hard working	Good sense of humor
Undesirable	Lazy		
Concentration difficulties	Can't make decisions	Can't do anything right	Other _____

What do you consider to be your craziest thought or idea?

Are you bothered by thoughts that occur over and over again?

If yes, what are these thoughts?

What worries do you have that may negatively affect your mood or behavior?

BEHAVIORS

Circle any of the following behaviors that often apply to you:

Overeat	Loss of control	Phobic avoidance
Take drugs	Suicidal attempts	Spend too much money
Unassertive	Compulsions	Can't keep a job
Odd behavior	Smoke	Insomnia
Drink too much	Withdrawal	Take too many risks
Work too hard	Nervous tics	Lazy
Eating problems	Procrastination	Concentration difficulties
Impulsive reactions	Sleep disturbance	Aggressive behavior
Crying		

What are some special talents or skills that you feel proud of?

What would you like to start doing?

What would you like to stop doing?

How is most of your free time occupied?

What kind of hobbies or leisure activities do you enjoy or find relaxing?

If you had any two wishes, what would they be?

FEELINGS

Circle any of the following feelings that often apply to you:

Angry	Fearful	Happy	Hopeful	Bored	Optimistic
Annoyed	Panicky	Conflicted	Helpless	Restless	Tense
Sad	Energetic	Shameful	Relaxed	Lonely	Depressed
Envious	Regretful	Jealous	Content	Anxious	
Guilty	Hopeless	Unhappy	Excited	Wired	

Please list your five main fears:

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

What are some positive feelings you have experienced recently?

When are you most likely to lose control of your feelings?

Describe any situations that make you feel calm or relaxed:

Highest level of education:

What were your strengths/weaknesses during your education?

Did you have any learning problems? If yes, please explain.

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily?

Do you keep them?

Did you date much during high school? College?

Were you ever bullied or severely teased?

Please describe any relationship that gives you joy:

Please describe any relationship that gives you grief:

Rate the degree to which you generally feel relaxed and comfortable in social situations:

Very relaxed 1 2 3 4 5 6 7 8 9 10 Very anxious

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts?

Marriage/Committed Relationship (please skip to the next section if not applicable)

How long have you been married?

How long did you know your marriage partner before engagement/marriage?

Spouse's age?

Spouse's occupation?

Describe your spouse's personality:

In what areas is there compatibility?

In what areas is there incompatibility?

What factors detract from your marital satisfaction?

On the scale below, please indicate how satisfied you are with your marriage:

Very dissatisfied 1 2 3 4 5 6 7 Very satisfied

How do you get along with your partner's friends and family?

Very poorly 1 2 3 4 5 6 7 Very well

Children (please skip to the next section if not applicable)

How many children do you have (if applicable)? ____ List their first names, gender, and ages:

Do any of your children present special problems?

Personality of each child:

Sexual Relationships

Describe your parents' attitudes towards sex (i.e., was there sex instruction or discussion in the home?)

When and how did you acquire your first knowledge of sex?

Did you ever experience anxieties or guilt feelings arising out of sex or sexual activities? ____ If yes, please explain:

Are there any relevant details regarding your first or subsequent sexual experiences?

Is your present sex life satisfactory? ____ If not, please explain.

Other Relationships

Are there any problems in your relationships with people at work?

If yes, please describe:

Please complete the following:

One of the ways people hurt me is:

I could shock you by:

My spouse/partner/boyfriend/girlfriend would describe me as:

My best friend thinks I am:

People who dislike me:

Are you currently troubled by any past rejections or loss of a love relationship?

If yes, please explain:

BIOLOGICAL FACTORS

Do you have any current concerns about your physical health?

If yes, please specify:

Please list any medications you are currently taking and why:

Do you eat three well-balanced meals each day?

Do you get regular physical exercise?

If yes, what type and how often?

Please list any significant medical problems that apply to you or to member of your family:

Any history of a high fever or head injury? If yes, please provide details:

Health during childhood:

List illnesses:

Health during adolescence:

List illnesses:

Date of your last physical exam:

Other relevant health information:

FAMILY AND CHILDHOOD DATA

Father, living or deceased?

If deceased, your age at the time of death?
Cause of death?

If alive, father's present age?

Occupation (if retired, what was the occupation)?

Mother, living or deceased?

If deceased, your age at the time of death?
Cause of death?

If alive, mother's present age?

Occupation (if retired, what was the occupation)?

Siblings:

Number of brothers? ____ Brother's ages?

Number of sisters? _____ Sister's ages?

Relationship with siblings, past *and* present?

Give a description of your father's personality and his attitude towards you ***when you were a child***:

Give a description of your father's personality and his attitude towards you ***currently***:

Give a description of your mother's personality and her attitude towards you ***when you were a child***:

Give a description of your mother's personality and her attitude towards you ***currently***:

In what ways did your parents discipline or punish you as a child?

Give an impression of your home atmosphere, (i.e., the home in which you grew up). Mention state of compatibility between parents, and between parents and children:

Were you able to confide in your parents?

Did you typically feel loved and respected by your parents when you were a child?

If you have a stepparent, give your age when parent remarried:

Give an outline of your religious training:

If you were not brought up by your parents, who brought you up and between what years?

Mother's condition during pregnancy (as far as you know):

Circle any of the following that applied during your childhood:

Night terrors

Stammering

Death in family

Legal trouble

Financial problems

Nail-biting

Fears

Emotional/behavior problems

Others: _____

Bed-wetting

Happy childhood

Ignored

School problems

Used alcohol

Drug use

Strong religious convictions

Sleepwalking

Eating disorder

Severely punished

Sexually abused

Severely bullied or teased

Not enough friends

Emotionally abused

Who are the most important people in your life? Why?

Does any member (that you know of or suspect) of your family suffer from alcoholism, epilepsy, depression, anxiety, or other disorders? Give details:

Has any relative attempted or committed suicide?

Are there any other members of the family about whom information regarding illness, etc., is relevant?

OCCUPATIONAL DATA

What sort of work are you doing now?

Types of jobs in the past?

Does your present work satisfy you? If not, in what ways are you dissatisfied?

Ambitions: past and present?

SITUATIONAL

Recount any fearful or distressing experiences not previously mentioned:

List any situations that make you feel particularly anxious:

List the benefits you hope to derive from counseling:

List any situations that make you feel calm or relaxed:

Have you ever lost control, i.e., temper, crying, aggression? _____ If so, please describe:

ADDITIONAL INFORMATION

Have you ever used drugs? _____ If yes, please explain:

Have you ever had any medical consequences of alcohol/drug usage (blackouts, seizures, shakes, hallucinations, etc...) _____ If yes, please explain:

Any legal problems related to alcohol/drug use _____ If yes, please explain:

Describe your pattern of alcohol usage:

Please describe any significant childhood (or other) memories and experiences you think may be relevant: