PURPOSE: This questionnaire asks for background information about your life so that we may use your consulting time more efficiently. Since much of this is highly personal, it is understandable that you may be concerned about its use. This information is held to be STRICTLY CONFIDENTIAL. NO OUTSIDERS are allowed to see any information without your WRITTEN PERMISSION.

If you do not wish to answer a particular question, cross it out or leave it blank.

I. GENERAL

Name: ____ Sex: M F Date: ____________
Age: ___________________ DOB: _________________ Race: ______ Ht/Wt: ___________

Reason you are seeking help or treatment: ____
____
____

II. PROBLEMS

Underline any of the following that apply to you:

Frequent headaches	Tired/No Energy	Overambitious
Other pain problems	Angry	Inferiority feelings
Dizziness	"Picked on"	Shy
Fainting spells	Bad dreams	Can't make friends
Heart racing	Depressed	Lonely
Nervousness	Unable to relax	Unhappy
Nausea/vomiting	Feel panicky	Frightened
No appetite	Feel tense/uptight	Legal problems
Can't sleep	Worried	Physically abused

PROBLEMS (continued)

Sleeping too much	Marital/family conflict	Fear of losing mind
Drinking too much	Sexual problems	Hearing strange voices/sounds
Taking drugs	Home conditions bad	Seeing strange visions
Poor health	Financial problems	Others controlling your thoughts
Bad nerves	Suicide ideas	Crying spells
Bad thoughts	Guilty feelings	

Other: ______________________________
____

III. PHYSICAL HISTORY
(Please circle)

YES NO NOT SURE 1. Have you received MEDICAL TREATMENT for any of the following problems? (If yes, please underline each)

Headaches	Ulcers	Head injury
Pain, other	Stomach/Colon	Hypoglycemia
Diabetes	Blackouts/Unconscious	TB
High blood pressure	Epilepsy/Seizures	Addison's disease
Heart trouble	Tumors/Cysts	Mitral valve disease
Thyroid trouble	Cancer	Venereal disease
Asthma	Other: ____________	Sleep disorder
Allergies	____________	
AIDS		

YES NO NOT SURE 2. Are you taking any medication? If yes, please list:
____
____
____

YES NO NOT SURE 3. Are you allergic to any medication? If yes, please list:
____
____
____

Family Doctor/Primary Care Physician: ____

Date of last physical exam or checkup: ____

Underline any medicine or drugs you have taken, now or in the past:

	Now	Past		Now	Past
Diet pills	____	____	Diabetes medicine	____	____
Alcohol	____	____	Seizure medicine	____	____
Pain killers	____	____	Birth control pills	____	____
Vitamins	____	____	"Speed/Uppers"	____	____
"Downers"	____	____	"Street drugs"	____	____
Tranquilizers	____	____	Blood pressure medicine	____	____
Tobacco	____	____	Antidepressants	____	____
Sleeping pills	____	____	Nerve medicine	____	____
Other	____	____	Caffeine (coffee, etc)	____	____

YES NO NOT SURE 4. Have you ever been hospitalized for any reason?
If yes, please explain: ____________________________
____
____

YES NO NOT SURE 5. Have you ever been treated for an emotional or mental condition? If yes, when: __________________
By whom: ___________ Hospitalized? ____________

YES NO NOT SURE 6. Have any of your close relatives or family members been treated for an emotional or mental condition?
If yes: what condition? ___________________________

YES NO NOT SURE 7. Have you ever received substance abuse treatment?

YES NO NOT SURE 8. Have any close relatives or family members ever had a problem with drugs or alcohol?

YES NO NOT SURE 9. Have you ever heard unusual noises or voices that other people nearby were not able to hear?

YES NO NOT SURE 10. Have you ever had visions of people or animals that seemed real?

YES NO NOT SURE 11. Have you ever smelled unusual odors that others nearby don't smell?

YES NO NOT SURE 12. Have you thought that someone else might be controlling your mind or putting thoughts into your head?

YES NO NOT SURE 13. Have you ever attempted suicide?

YES NO NOT SURE 14. Have you been thinking about suicide lately?

YES NO NOT SURE 15. Have you lost or gained an unusual amount of weight lately?

Lost _________ lbs Gained ________ lbs

YES NO NOT SURE 16. Has your sexual interest/behavior changed recently?

YES NO NOT SURE 17. (Females) Have there been any recent changes in your menstrual cycle regularity?

YES NO NOT SURE 18. Have you ever had periods of time when you were so full of plans and energy that you felt you had to keep busy all the time and got by on very little sleep without feeling tired?

IV. SOCIAL HISTORY

A. INTERPERSONAL

19. Where were you born/raised? ___________________

20. Father's Occupation: __________________________

21. Mother's Occupation: _________________________

22. Number of Siblings: __________________________

23 What is your position in your family origin? (eg. - oldest, youngest, etc) _____________________

24. Were you ever raised by someone other than your natural parents? If yes, who: ____________________

YES NO NOT SURE 25. Did you have an unhappy childhood?

YES NO NOT SURE 26. Were you ever abused or mistreated as a child or teenager?

YES NO NOT SURE 27. Were you often in poor health as a child or teenager?

YES NO NOT SURE 28. Were you very poor when growing up?

YES NO NOT SURE 29. Did you have a poor relationship with your father?

YES NO NOT SURE 30. Did you have a poor relationship with your mother?

31. Choose three words to describe your mother: _______
____

32. Choose three words to describe your father: ________
____

33. What important expectations were held for children growing up in your family of origin? ______________
____
____

YES NO NOT SURE 34. Were you especially close to any adult(s) other than your parents? If yes, who: ______________________
____

YES NO NOT SURE 35. Was religion a major part of your upbringing?

YES NO NOT SURE 36. Is religion a major part of your life now?

37. How was affection expressed in the home where you grew up? ____________________________________
____

38. How was anger expressed by you in the home where you grew up? ________________________________
____

YES NO NOT SURE 39. Were there any unusual or very disturbing experiences in your childhood? If yes, please explain.

____
____
____

YES NO NOT SURE 40. Do you feel your current problems may be directly related to the way you were raised? (If yes, please explain on the back of the page.)

At what age ( ) and under what circumstances did you leave home? ______________________________
____
____

B. SCHOOL

YES NO NOT SURE 41. Did you graduate from high school? (If no, give highest grade completed) ______________________

YES NO NOT SURE 42. Did you have any post high school training or college? (If yes, please describe) ________________
____

YES NO NOT SURE 43. Were you generally a below average student?

YES NO NOT SURE 44. Were you generally an above average student?

YES NO NOT SURE 45. Were you a behavior problem in school or when growing up?

YES NO NOT SURE 46. Were you ever in trouble with the law or juvenile authorities while growing up?

YES NO NOT SURE 47. Have you been in trouble with the law as an adult?

YES NO NOT SURE 48. Do you have adequate social support family/friends)?

49. How do you spend your free time? _______________
____
____

50. What are your ambitions in life? ____________________
____

51. What do you do for fun? ____________________________
____

C. OCCUPATIONAL HISTORY

YES NO NOT SURE 52. Are you presently employed? (If yes, describe occupation) ______________________________
____
____

YES NO NOT SURE 53. Are you satisfied with your present work?

YES NO NOT SURE 54. Are there problems in the job that you wish to discuss with your counselor?

55.

	JOBS HELD	HOW LONG	WHY LEFT
A.	______________	____________	_____________
B.	______________	____________	_____________
C.	______________	____________	_____________
D.	______________	____________	_____________
E.	______________	____________	_____________

V. SEXUAL HISTORY

YES NO NOT SURE 56. Are you currently sexually active?

YES NO NOT SURE 57. Is sex a problem area for you?

YES NO NOT SURE 58. Is sex a problem area for any member of your family?

YES NO NOT SURE 59. Is your present sex life satisfactory to you?

YES NO NOT SURE 60. Have you had any unusual sexual experiences?

YES NO NOT SURE 61. Have you ever gotten into trouble over sex matters?

YES NO NOT SURE 62. Have you experienced anxiety or guilt over sex or masturbation?

63. Approximately how many sexual partners have you had? ________________

YES NO NOT SURE 64. Did your first sexual experience occur before age 18? If yes, at what age: ___________

YES NO NOT SURE 65. Are you strongly attracted to members of the same sex?

YES NO NOT SURE 66. Are you sexually inhibited in any way?

YES NO NOT SURE 67. Do you have any physical or medical problem which affects your sex life?

YES NO NOT SURE 68. Would you like to discuss sexual matters with your counselor?

YES NO NOT SURE 69. Does it make any difference to you whether your counselor is a man or woman?

VI. MARITAL (If you have never been married, please go to Question 75)

70. How long have you been married? ________________

YES NO NOT SURE 71. Have you been married more than once? (If yes, please describe earlier marriage on back of this page)

YES NO NOT SURE 72. Are you now living with a spouse? (If yes, list names and ages of spouse and children) __________________
____

YES NO NOT SURE 73. Are you now living alone or with somebody who is not your spouse? (If yes, go to VII Personal Section)

YES NO NOT SURE 74. Is the marriage in trouble?

YES NO NOT SURE 75. Are there areas of incompatibility in the marriage? (If yes, please describe) ____________________________
____

YES NO NOT SURE 76. Do you have any problems with relatives or in-laws?

YES NO NOT SURE 77. Are there any issues about your marriage you wish to discuss with your counselor?

YES NO NOT SURE 78. Is your spouse willing to participate in counseling?

YES NO NOT SURE 79. If never married, are you now involved in a serious relationship with anyone?

VII. PERSONAL

A. UNDERLINE any words which apply to you.

competent	confident	shy	lonely
"a nobody"	not confident	weak	unloved
intelligent	guilty	strong	loving
stupid	evil	superstitious	kind
attractive	morally wrong	outgoing	considerate
unattractive	irritable	friendly	quiet
plain	angry	neat	loud
ugly	aggressive	messy	bored
repulsive	timid	disorganized	restless
a loner	misunderstood	confused	regretful
nervous	jumpy	OTHERS: ______________________	

____

B. Please complete the following sentences:

I am a person who ____

All my life ____

I am proud of ____

I regret ____

It's hard to admit that ____

I can't forgive ______________________________

Life is ______________________________

Mother ______________________________

Father ______________________________

I would like to change ______________________________

My earliest memory is ______________________________

My motto is ______________________________

I like ______________________________

My greatest fear ______________________________

What makes me angry is ______________________________

I can't ______________________________

I am embarrassed ______________________________

I secretly ______________________________

YES NO — Is there anything of importance that was missed by this questionnaire? If so, please explain: ______________________________
____
____
____

Treatment Goals: What do you hope to gain or accomplish through counseling? ______________________________
____
____