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Name: ________________________________ **Date:** ________

DOB: ______ **Circle One:** Male Female

Address: ____

Telephone numbers: (day) _____________ **(evening)** _____________

Personal Data

A. Place of birth: ____________________

B. As far as you know, were there any problems with your mother's pregnancy or delivery of you?

a. Yes
b. No
If yes, please give details:

C. As far as you know, did you walk, talk, and sit up on time?

a. Yes
b. No
If no, please give details:

D. Did you have any childhood illnesses?

a. Yes
b. No
If yes, please give details:

E. Did you have any childhood injuries?

a. Yes
b. No
If yes, please give details:

F. Did you have normal relationships with your peers when you were a child?

a. Yes
b. No
If no, please give details:

G. Where you ever bullied or severely teased?
a. Yes
b. No
If yes, please give details:

H. What is the last grade of school you completed? ____________________

____

I. Scholastic abilities: strengths and weaknesses ______________________

____

J. Check any of the following that applied during your childhood:

__Night terrors __Bedwetting __Sleepwalking
__Thumb sucking __Nail biting __Stammering
__Fears __Happy childhood __Unhappy childhood
__Others: _______________________

K. Please detail any of the following that you have had:

Accidents: ____

Surgeries: ____

Hospitalizations: ____

L. Name of your Physician______________________ Phone #____________

M. Date of last Medical Examination _______________________

N. Do you have a diagnosed medical condition (ex: diabetes, asthma):

____

O. Circle any of the following that **currently** apply to you:

headaches	dizziness	fainting spells
palpitations	stomach trouble	anxiety
bowel disturbances	fatigue	no appetite
anger	take sedatives	insomnia
nightmares	feel panicky	alcoholism
feel tense	conflict	tremors
depressed	suicidal ideas	take drugs
unable to relax	sexual problems	allergies
don't like weekends and vacations	overambitious	shy with people
can't make friends	inferiority feelings	can't make decisions
can't keep a job	memory problems	home conditions bad
financial problems	lonely	unable to have a good time
excessive sweating	often use aspirin or pain killers	concentration difficulties

P. Please list additional problems or difficulties here:

____

____

____

____

Q. Circle any of the following words that **currently** apply to you:

Worthless, useless, a "nobody," "life is empty"
Inadequate, stupid, incompetent, naïve, "can't do anything right"
Guilty, evil, morally wrong, horrible thoughts, hostile, full of hate
Anxious, agitated, cowardly, unassertive, panicky, aggressive
Ugly, deformed, unattractive, repulsive
Depressed, lonely, unloved, misunderstood, bored, restless
Confused, unconfident, in conflict, full of regrets
Worthwhile, sympathetic, intelligent, attractive, confident, considerate
Please list any additional words:

____

R. Present interests, hobbies, and activities: ____________________________

____

S. How is most of your free time occupied? ____________________________

____

T. Do you make friends easily?

a. Yes

b. No
If no, please give details:

U. Do you take any medications?
a. Yes
b. No
If yes, and please give details:

V. If yes, who Prescribes your medication:______________________________

W. Do you take any over the counter medications?
a. Yes
b. No
If yes, please give details:

X. Are you currently using or have you abused alcohol or other drugs?

a. Yes

b. No

If yes, please give details: ______________________________________

____

Y. How much do you smoke?
a. Never smoked
b. Have quit for more than a year
c. Have quit for less than a year
d. Less than half a pack per day (ppd)
e. Half to one ppd
f. One to two ppd
g. Two or more ppd

Z. How much caffeine do you drink, including caffeinated tea and soda?
a. None
b. 1-2 cups per day
c. 3-4 cups per day
d. 5-6 cups per day
e. 7-10 cups per day
f. 11+ cups per day

Occupational Data

A. What work are you doing now? ____________________________________

B. List previous jobs over the past five years: ___________________________

____

C. Does your present work satisfy you?
a. Yes

b. No
If no, please give details:

D.: Past Ambitions/Goals: ____

____

Present Ambitions/Goals: ____

____

E. Have you served in the military?
a. Yes
b. No
If yes, please give details (highest rank, special honors, duties, discharge status):

Marital History

A. What is your current marital status?
a. Never married
b. Married
c. Separated
d. Divorced
e. Widowed

B. Are you currently in an intimate relationship?

a. Yes

b. No

If yes, for how long?

a. Less than 3 months
b. 3-6 months
c. 7 months – 1 year
d. 1-5 years
e. 5-10 years
f. 10+ years

C. How many intimate relationships have you had that lasted more than 3 months?

a. None
b. One or two
c. Three or four
d. Five or more

D. If married, how long did you know your marriage partner before you married? ____

E. How long have you been married? ___________________________________

____

F. Did you have any prior marriages?

a. Yes
b. No

If yes, please give details:

G. Please list the gender and ages of your children: ______________________

____

H. Please describe anything else of importance regarding your marriage and/or marital history: ____

____

Family Data

A. Is your father living or deceased? ____________________________________

B. If deceased, what was your age at time of his death? __________________

C. Cause of death? ____

D. Is your mother living or deceased? __________________________________

E. If deceased, what was your age at time of her death? __________________

F. Cause of death? ____

G. Please list the gender and ages of your siblings: _______________________

____

H. If you were not raised by your parents, who raised you, and between what years? ____

____

I. Are there any medical illnesses that run in your family?

a. Yes
b. No

If yes, please give details:

J. Is there anyone in your family who has had problems with anxiety or depression?

a. Yes
b. No

If yes, please give details:

K. Is there anyone in your family who has abused alcohol or other drugs?

a. Yes
b. No

If yes, please give details:

L. Is there anyone in your family who has had any psychiatric illness?

a. Yes
b. No

If yes, please give details:

M. Is there anyone in your family who has been in trouble with the law?

a. Yes
b. No

If yes, please give details:

N. Is there anyone in your family who has had seizures or other neurological problems?

a. Yes
b. No

If yes, please give details:

O. Is there anyone in your family who has had heart problems?

a. Yes
b. No

If yes, please give details:

P. Is there anyone in your family who has high blood pressure?

a. Yes
b. No

If yes, please give details:

Q. Is there anyone in your family who has had attentional problems?

a. Yes
b. No

If yes, please give details:

R. Is there anyone in your family who has had learning disabilities?

a. Yes
b. No

If yes, please give details:

Treatment Needs

What do you expect to accomplish from therapy, and how long do you expect therapy to last? ____

____

What is there about your present behavior that you would like to change?

____

____

What feelings do you wish to alter (e.g., increase or decrease)? ___________

____

____

List any situation that makes you feel calm or relaxed: __________________

____

List any situation that makes you feel upset or angry: ____________________

____

Have you ever lost control (e.g. temper, crying, or aggression)? If so, please describe: ____

____

Please add any information not brought up by this questionnaire that may aid your therapist in understanding and helping you: ____________________

____

____

In a few words, what do you think therapy is all about? _________________

____

____