

Please complete these questions as fully and accurately as possible. It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential. **ONLY YOUR PROVIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR WRITTEN PERMISSION**.

*Please write carefully so that we may read your responses clearly*

Date: / / Name: Age: Date of Birth / /

Address:

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best Phone Number to Reach You: ( )

May I leave a message at this number? yes | no

Place of Employment:

How did you hear about us? Personal Referral by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Internet (please list site): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (please be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Status (circle): Single | Dating | Engaged | Married | Separated | Divorced Widowed | Consecrated Celibate | Remarried (number of times\_\_\_)

Religion: As a child As an adult:

Parish / Church:

Ethnic Origin (circle):

Caucasian Black Hispanic Native American Asian Other:

Name of person(s) to be contacted in case of emergency:

Name Relationship Phone Number

Medical Information

Name of Physician: Ph#: Date of last exam:

Major Health Problems:

Medications Presently Taking:

Past prescription medications:

**Analysis of Current Problems:**

State in your own words the nature of your problems.

On the line below, please make a mark to estimate the severity of your problem(s):

---------------------------------------------------------------------------------------------------------------------

Mild Moderately Very Extremely Totally

Upsetting Upsetting Severe Severe Incapacitating

Why are you seeking our services now?

When did your problems begin? (give dates):

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of your problems:

What solutions to your problems have been most helpful?

Have you been in therapy before or received any prior professional assistance for your problems?

If so, please give name(s), professional titles(s), dates of treatments, and results:

Have you ever been hospitalized for psychological problems? Yes / No If yes, when and where?

Have you ever attempted suicide? Yes / No If yes, how long ago?

Do you have any current thoughts of suicide?

Were there any complications during your birth? If so, please describe.

Were you ever in daycare? Yes / No

If yes, provided by whom? ­­­­­­­­­­­­­­­­­­­­­­­­

At what ages?

How many days per week? How many hours per day?

Please describe any surgery you have had and provide dates:

Please describe any accident or injuries you have suffered including head injury or loss of consciousness and provide dates.

Have you ever experienced any kind of abuse? Yes / No

Sexual Verbal Physical Emotional (e.g., extreme mind games or guilting)

**Expectations regarding therapy:**

In a few words, what do you hope to gain from therapy?

How long do you think your therapy should last?

**Faith:**

In your own words, describe your faith.

**Social Dynamics:**

Who are the most important people in your life?

Do you make friends easily? Do you keep them?

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

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

**Very relaxed Relatively comfortable Relatively uncomfortable Very anxious**

Generally, do you express your feelings, opinions, and wishes to others in an open, appropriate manner? Y / N Describe those individuals with whom (or those situations in which) you have trouble asserting yourself.

Did you date much during High School? College?

Please list academic strengths:

Describe your experience during each stage of school (i.e. friendships, sports, clubs/organizations, honors, etc.).

Grade School:

Junior High:

High School:

College:

Any behavioral or academic difficulties?

**Employment:**

Please list your employment history, beginning with the most recent.

**Place Position Dates Reason for leaving**

Does your present work satisfy you? If not, please explain.

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

What are your past employment ambitions?

What are your current ambitions?

**Family Dynamics:**

Are you adopted? Yes \_\_\_\_ No \_\_\_\_ If yes, at what age?

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

Give a description of your father’s personality and his attitude toward you (past and present):

Give a description of your mother’s personality and her attitude toward you (past and present):

In what ways were you disciplined as a child?

If you have a step-parent(s), give your age when parent remarried.

Indicate any significant life events for the family.

Please list any family strengths.

*Circle* any of the following that apply to you and place a *checkmark* (✓) next to those that apply to members of your family:

\_\_Thyroid disease \_\_Asthma \_\_Kidney disease \_\_Neurological disease

\_\_Infectious diseases \_\_Diabetes \_\_Cancer \_\_Gastrointestinal disease

\_\_Prostate problems \_\_Glaucoma \_\_Epilepsy \_\_Other:

Does any member of your family suffer from alcoholism or drug abuse? (if so, please indicate relation and duration):

Anxiety or depression?

Mental illness?

Has any relative attempted or committed suicide?

Have you or any relatives had serious criminal problems?

Have you or anyone in your family had an abortion?

**Current Marriage:**

How long did you know your spouse before your engagement?

How long have you been married?

Describe your spouse’s personality.

What are the strongest aspects of your marriage? (i.e., communication, shared interests)

What areas are in need of strengthening?

How do you get along with your in-laws (this includes brothers and sisters-in-law)?

Do any of your children present special problems?

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| --- | --- | --- | --- | --- | --- | --- |
|  | Name | Sex | Age | Describe your relationship | Deceased? (Y/N) | If yes, give cause of death and your age when it happened |
| Father |  |  |  |  |  |  |
| Mother |  |  |  |  |  |  |
| Step-father |  |  |  |  |  |  |
| Step-mother |  |  |  |  |  |  |
| Siblings  (indicate if  step or half  siblings) |  |  |  |  |  |  |
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| Spouse |  |  |  |  |  |  |
| Children  (indicate if  step-children) |  |  |  |  |  |  |
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| Others  (ex-spouses, others living in home, roommates, etc.) |  |  |  |  |  |  |
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Self Perceptions:

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

Angry Guilty Unhappy Annoyed Happy Bored

Sad Conflicted Restless Depressed Regretful Lonely

Anxious Hopeless Contented Fearful Hopeful Excited

Panicky Helpless Optimistic Energetic Relaxed Tense

Envious Jealous Confused Numb Others:

List your three main fears:

1.

2.

3.

*Circle* each of the following words that you might use to describe yourself:

Intelligent Confident Worthwhile Ambitious Sensitive

Loyal Trustworthy Full of regrets Worthless A Nobody

Useless Evil Crazy Considerate A Deviant

Unattractive Unlovable Inadequate Confused Ugly

Stupid Naïve Conflicted Funny Honest

Horrible thoughts Hard-working Suicidal ideas Persevering Attractive

Morally degenerate Memory problems Concentration difficulties Can’t make decisions

What do you consider to be your most irrational thought or idea?

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

On each of the following items, please *circle* the number that most accurately reflects your opinions:

Strongly Strongly

Disagree Disagree Neutral Agree Agree

I should not make mistakes. ---1--- ---2--- ---3--- ---4--- ---5---

I should be good at everything I do. ---1--- ---2--- ---3--- ---4--- ---5---

When I do not know, I should pretend I do. ---1--- ---2--- ---3--- ---4--- ---5---

I should not disclose my personal info. ---1--- ---2--- ---3--- ---4--- ---5---

I am a victim of circumstances. ---1--- ---2--- ---3--- ---4--- ---5---

My life is controlled by outside forces. ---1--- ---2--- ---3--- ---4--- ---5---

Other people are happier than I am. ---1--- ---2--- ---3--- ---4--- ---5---

It is very important to please other people. ---1--- ---2--- ---3--- ---4--- ---5---

Play it safe; don’t take any risks. ---1--- ---2--- ---3--- ---4--- ---5---

I don’t deserve to be happy. ---1--- ---2--- ---3--- ---4--- ---5---

If I ignore my problems, they will disappear. ---1--- ---2--- ---3--- ---4--- ---5---

It is my responsibility to make others happy. ---1--- ---2--- ---3--- ---4--- ---5---

I should strive for perfection. ---1--- ---2--- ---3--- ---4--- ---5---

Basically, there are two ways of doing ---1--- ---2--- ---3--- ---4--- ---5---

things, the right way and the wrong way.

Please check (✓) the appropriate boxes for the following conditions.

**Never In the past Rarely Sometimes Very often**

Illegal drug use --❑-- --❑-- --❑-- --❑-- --❑--

Sedatives --❑-- --❑-- --❑-- --❑-- --❑--

Aspirin --❑-- --❑-- --❑-- --❑-- --❑--

Alcohol --❑-- --❑-- --❑-- --❑-- --❑--

Coffee --❑-- --❑-- --❑-- --❑-- --❑--

Caffeinated Soda --❑-- --❑-- --❑-- --❑-- --❑--

Cigarettes --❑-- --❑-- --❑-- --❑-- --❑--

Eating problems --❑-- --❑-- --❑-- --❑-- --❑--

Allergies --❑-- --❑-- --❑-- --❑-- --❑--

High blood pressure --❑-- --❑-- --❑-- --❑-- --❑--

Heart problems --❑-- --❑-- --❑-- --❑-- --❑--

Nausea or Vomiting --❑-- --❑-- --❑-- --❑-- --❑--

Headaches --❑-- --❑-- --❑-- --❑-- --❑--

Backache --❑-- --❑-- --❑-- --❑-- --❑--

Sleep disturbances --❑-- --❑-- --❑-- --❑-- --❑--

Procrastination --❑-- --❑-- --❑-- --❑-- --❑--

Crying --❑-- --❑-- --❑-- --❑-- --❑--

Repetitive behaviors --❑-- --❑-- --❑-- --❑-- --❑--

Concentration difficulties --❑-- --❑-- --❑-- --❑-- --❑--

Repetitive thoughts --❑-- --❑-- --❑-- --❑-- --❑--

Impulsive reactions --❑-- --❑-- --❑-- --❑-- --❑--

Take many risks --❑-- --❑-- --❑-- --❑-- --❑--

Aggressive behavior --❑-- --❑-- --❑-- --❑-- --❑--

Phobic avoidance --❑-- --❑-- --❑-- --❑-- --❑--

Withdrawal --❑-- --❑-- --❑-- --❑-- --❑--

Lazy --❑-- --❑-- --❑-- --❑-- --❑--

Temper outbursts --❑-- --❑-- --❑-- --❑-- --❑--

Twitches or tremors --❑-- --❑-- --❑-- --❑-- --❑--

Fainting spells --❑-- --❑-- --❑-- --❑-- --❑--

Dry mouth --❑-- --❑-- --❑-- --❑-- --❑--

Watery eyes --❑-- --❑-- --❑-- --❑-- --❑--

Stomach trouble --❑-- --❑-- --❑-- --❑-- --❑--

Chest pains --❑-- --❑-- --❑-- --❑-- --❑--

Blackouts --❑-- --❑-- --❑-- --❑-- --❑--

Numbness --❑-- --❑-- --❑-- --❑-- --❑--

Skin problems --❑-- --❑-- --❑-- --❑-- --❑--

Hear things --❑-- --❑-- --❑-- --❑-- --❑--

Dizziness --❑-- --❑-- --❑-- --❑-- --❑--

Rapid heart beat --❑-- --❑-- --❑-- --❑-- --❑--

Bowel disturbances --❑-- --❑-- --❑-- --❑-- --❑--

Visual disturbances --❑-- --❑-- --❑-- --❑-- --❑--

Nervous, worried or anxious --❑-- --❑-- --❑-- --❑-- --❑--