DOLORES J. GUARINI, Ph.D., LLC
615 Washington Road, Suite 507
Pittsburgh, PA 15228
Tel.: 412-892-9044 Fax: 412-892-9702
dolores@guarini-phd.com

Date: _____ Referred By: _____

I. IDENTIFYING DATA

a. Patient Name: _____ D.O.B. _____ Sex: ☐ M ☐ F

b. Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

c. Spouse's Name: _____ When Married? : _____

d. Names of People Who Live With You:

Name: Relationship: Occupation: Age:

_____

_____

_____

_____

e. Employment

What is your occupation?

_____

Are you working at present? ☐ Yes ☐No

If Yes: ☐ Full-Time ☐ Part –Time

How long have you held your current job?

_____

II. PRESENTING PROBLEM

a. Briefly describe the problem that has caused you to seek counseling.

_____

_____

_____

b. How long has this difficulty been going on?

_____

c. What are the stressors in your life that contribute to the problem?

_____

_____

_____

d. What would you like to accomplish in therapy?

_____

_____

_____

III. HISTORY

a. Developmental

1. Where were you born? _____

2. Where were you raised? _____

3. Were you an active child? ☐ Yes ☐ No

4. Did you have friends? ☐ Yes ☐ No

5. Was your family intact? ☐ Yes ☐ No

If no, what were the events that disrupted the family?

☐ Death ☐ Divorce ☐ Illness ☐ Other _____

6. Were there any unusual circumstances in your childhood, such as

Accidents_____

Illnesses _____

Several moves necessitating changing schools _____

Other _____

7. Did you have any of the following behaviors as a child? Indicate age.

☐ Frequent Temper Outbursts ☐ Excessive Fears

☐ Frequent Nightmares ☐ Bed Wetting

☐ Excessive Shyness ☐ Fire Setting

☐ Other _____

Explain _____

8. As a teenager, did you have any of the following problems? Indicate age.

☐ Trouble with the Police ☐ Alcohol Use

☐ Trouble with School Authority ☐ Drug Use

☐ Running Away from Home ☐ Truancy

☐ Unwanted Pregnancy (self/girlfriend) ☐ Criminal Acts

☐ Other _____

Explain _____

b. Academic

1. What is the highest level of education you have completed? _____

2. Are you currently in school? _____If so, where? _____

3. What are your grades like in school? _____

4. Did you participate in extracurricular activities? _____ If yes, give examples _____

c. Family

1. Has there been any physical abuse or domestic violence in your family?
□ Yes □ Denied
If yes, were you the □ Victim □ Perpetrator □ Both □ Neither
2. Has there been any sexual abuse in your family?
□ Yes □ Denied
If yes, were you the □ Victim □ Perpetrator □ Both □ Neither
3. How are your relationships with the following ?
Father _____
Mother _____
Children _____
Siblings _____
Peers _____
4. Have any of your relatives suffered from the following problems? If so, please identify relative.
Alcoholism _____
Drug Addiction _____
Depression _____
Anxiety, Fears, Phobias_____
Bi Polar Disorder _____
Suicide or Attempted Suicide _____
Other Psychological Problems _____

d. Medical

1. Primary Care Physician_____
2. Is PCP your source of referral? □ Yes □ No
3. Do you want PCP to be notified you are in therapy? □ Yes □ No
4. Describe any medical problems you have _____
_____
_____
_____
_____
5. How long ago was your last physical? _____
6. Are you on any medications currently? □ Yes □ No
If yes, please list them: _____
_____
_____
7. Do you have any medical allergies? □ Yes □ No
If yes, please list them:
_____
_____

e. Psychiatric

1. Previous Treatment ☐ Yes ☐ No If yes:

a. Inpatient Treatment

Where Dates Reason

_____

_____

_____

b. Outpatient Treatment

Where Dates Reason

_____

_____

_____

c. Were you placed on any medication? ☐ Yes ☐ No

If yes, please list them: _____

_____

d. Did you ever make a suicide attempt? ☐ Yes ☐ No

If yes, please answer:

Date Manner of Attempt Reason

_____

_____

_____

f. Drug/Substance Abuse Therapy

1. Previous Treatment ☐ Yes ☐ No
2. Inpatient Treatment ☐ Yes ☐ No If yes:

Where Dates Reason

_____

_____

_____

3. Outpatient Treatment ☐ Yes ☐ No If yes:

Where Dates Reason

_____

_____

_____

IV. LEGAL

a. Are you currently involved in any legal action? □ Yes □ No
If yes, please describe:

_____
_____
_____

b. Have you ever been arrested? □ Yes □ No
If yes, please describe:

_____
_____
_____

V. LIFESTYLE

a. Do you smoke? □ Yes □ No If yes, How many per day? _____
b. Do you drink caffeine? □ Yes □ No If yes, how many servings per day? _____
c. Do you drink alcohol? □ Yes □ No
If yes, indicate what you drink and how many drinks you have per day:

_____
_____

d. Do you use drugs recreationally? □ Yes □ No
If yes, please indicate what type of drug and how frequently it is used:

_____
_____

e. Do you have a weight or eating problem? □ Yes □ No
If yes, please describe:

_____
_____

f. Is there anything else you would like us to know about your situation?

_____
_____
_____
_____

DATE: _____SIGNATURE: _____