

Please fill this form out prior to our first appointment. If you feel uncomfortable with any of the questions or with the form itself, please let me know.

Today's date: ____/____/____

Chief concerns:

Please describe the main difficulties that have brought you to see me:

Treatment:

Have you ever received psychological or psychiatric or counseling services before?

If yes, please indicate:

When? From whom? For what? With what? Results?

Have you ever taken medications for psychiatric or emotional problems?

If yes, please indicate:

When? From whom? Which medications? For what? Results?

Family-of-origin history:

Relative	Current Age	Education	Occupation	If deceased, age of death & cause
Father				
Mother				
Brothers				
Sisters				
Stepparents				
Grandparents				
Uncles				
Aunts				

Relationships in your family of origin. Please describe the following:

Your parents' relationship with each other:

Your relationship with each parent and with other adults present:

Your parents' physical health problems, chemical use, and mental or emotional difficulties:

Your relationship with your brothers and sisters (if any), in the past and present:

Abuse history: ___ I was not abused in any way. ___ I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Kind of abuse:

Age?

By whom?

Effects on you?

Whom did you tell?

Consequences of telling?

Present Relationships:

Marital/relationship history:

Children (Indicate which are from a previous marriage or relationship with the letter P in the last column):

Name	Current age	Sex	School	Grade	Adjustment problems?	P?
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How do you get along with your children, if any?

Significant nonmarital relationships:

Your important friends, past and present:

Name	Good parts of relationship	Bad parts of relationship

Chemical use

- 1. Have you ever felt the need to cut down on your drinking? (circle one) Yes No
- 2. Have you ever felt annoyed by criticism of your drinking? (circle one) Yes No
- 3. Have you ever felt guilty about your drinking? (circle one) Yes No
- 4. Have you ever taken a morning "eye-opener"?(circle one) Yes No
- 5. How much beer, wine, or hard liquor do you consume each week, on the average?

6. How much tobacco do you smoke or chew each week?

7. Which drugs (not medications prescribed for you) have you used in the last 10 years?
Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

Legal history

Are you presently suing anyone or thinking of suing anyone? If yes, please explain:

List all the contacts with the police, courts, and jails/prisons you have had. Include all open charges and pending ones.

Checklist of Concerns:

Please check all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

<ul style="list-style-type: none"> <input type="checkbox"/> Abuse—physical, sexual, emotional, neglect (of children or elderly), cruelty to animals <input type="checkbox"/> Aggression, violence <input type="checkbox"/> Alcohol use <input type="checkbox"/> Anger, hostility, arguing, irritability <input type="checkbox"/> Anxiety, nervousness <input type="checkbox"/> Attention, concentration, distractibility <input type="checkbox"/> Career concerns, goals, and choices <input type="checkbox"/> Childhood issues (your own childhood) <input type="checkbox"/> Children, child management, child care, parenting <input type="checkbox"/> Codependence <input type="checkbox"/> Confusion <input type="checkbox"/> Compulsions <input type="checkbox"/> Custody of children <input type="checkbox"/> Decision making, indecision, mixed feelings, putting off decisions <input type="checkbox"/> Delusions (false ideas) <input type="checkbox"/> Dependence <input type="checkbox"/> Depression, low mood, sadness, crying <input type="checkbox"/> Divorce, separation <input type="checkbox"/> Drug use—prescription medications, over-the-counter medications, street drugs <input type="checkbox"/> Eating problems—overeating, undereating, appetite, vomiting <input type="checkbox"/> Emptiness <input type="checkbox"/> Failure <input type="checkbox"/> Fatigue, tiredness, low energy <input type="checkbox"/> Fears, phobias <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income <input type="checkbox"/> Friendships <input type="checkbox"/> Gambling <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce <input type="checkbox"/> Guilt <input type="checkbox"/> Headaches, other kinds of pains <input type="checkbox"/> Health, illness, medical concerns, physical problems <input type="checkbox"/> Inferiority feelings <input type="checkbox"/> Interpersonal conflicts <input type="checkbox"/> Impulsiveness, loss of control, outbursts 	<ul style="list-style-type: none"> <input type="checkbox"/> Irresponsibility <input type="checkbox"/> Judgment problems, risk taking <input type="checkbox"/> Legal matters, charges, suits <input type="checkbox"/> Loneliness <input type="checkbox"/> Marital conflict, distance/coldness, infidelity/affairs, remarriage <input type="checkbox"/> Memory problems <input type="checkbox"/> Menstrual problems, PMS, menopause <input type="checkbox"/> Mood swings <input type="checkbox"/> Motivation, laziness <input type="checkbox"/> Nervousness, tension <input type="checkbox"/> Obsessions, compulsions (thoughts or actions that repeat themselves) <input type="checkbox"/> Oversensitivity to rejection <input type="checkbox"/> Panic or anxiety attacks <input type="checkbox"/> Perfectionism <input type="checkbox"/> Pessimism <input type="checkbox"/> Procrastination, work inhibitions, laziness <input type="checkbox"/> Relationship problems <input type="checkbox"/> School problems (see also "Career concerns") <input type="checkbox"/> Self-centeredness <input type="checkbox"/> Self-esteem <input type="checkbox"/> Self-neglect, poor self-care <input type="checkbox"/> Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse") <input type="checkbox"/> Shyness, oversensitivity to criticism <input type="checkbox"/> Sleep problems—too much, too little, insomnia, nightmares <input type="checkbox"/> Smoking and tobacco use <input type="checkbox"/> Stress, relaxation, stress management, stress disorders, tension <input type="checkbox"/> Suspiciousness <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Temper problems, self-control, low frustration tolerance <input type="checkbox"/> Thought disorganization and confusion <input type="checkbox"/> Threats, violence <input type="checkbox"/> Weight and diet issues <input type="checkbox"/> Withdrawal, isolating <input type="checkbox"/> Work problems, employment, workaholism/overworking, can't keep a job
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Any other concerns or issues:

Please look back over the concerns you have checked off and star the ones that you most help with.

List at least 10 strengths, assets, or things you are proud of about yourself.

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

What are your goals for therapy?

Life Events Summary: On a separate sheet of paper (or on the back of this page), reflect on your life from birth to present in terms of the highlights, challenges, celebrations, relationships, enduring circumstances, turning points, accomplishments, losses, adventures, and the peaks and valleys that have shaped who you are as a person. You can do this in chart form or narrative form. Summarizing the main aspects of your life history will save us time in therapy.

Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: