

Section 2: Employment/School Information

What is your current employment or educational status (working full-time, part-time, at home with children, in college, unemployed, etc.)?

What do you do for work, if you do work? _____

Name of employer or school (if applicable): _____

What kinds jobs have you held in the past (in chronological order)?

If you are in school, what school do you attend? _____

What degree are you trying to obtain? _____

What are you hoping to do upon graduation? _____

Section 3: Family and Relationship Information

Marital Status:

- Never Married Domestic Partnership Married Engaged
 Separated Divorced Widowed

In terms of sexual orientation, how do you identify?

- Heterosexual Homosexual (Gay/Lesbian) Bisexual Questioning
 Other _____ Prefer not to answer

Is this problematic for you at all?

If you are presently in a relationship, how long have you been in this relationship?

On a scale of 1-10 (if 1 = not at all satisfied, 10= extremely satisfied), how would you rate your current relationship in terms of satisfaction?

How could you move that number up a number or two?

Please describe your relationship with your partner. Your attitudes toward each other, how you handle conflict, etc.

If you are not in a relationship and have been before, please describe your relationship history (name of person/people, how long dated, when relationship ended, etc.)

If you are not in a relationship and have not been in one as of yet, how important is it to you to be in a relationship? What do you hope for in the future in terms of a relationship?

If you have children, how did having children affect your relationship with your spouse?

Please list all of your children (if any)

Name	Age	Sex	By this marriage, previous, adopted	Living at home?
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List previous marriages and state if they ended in divorce or death

Please note any important family members (spouse/partner, children, siblings, parents, relatives, etc.) using the categories below:

Name: _____ Relationship to you: _____ Age if living OR year of death: _____ Where do they live? _____

Please describe your father's personality and his attitude toward you (past and present):

Please describe your mother's personality and her attitude toward you (past and present):

Please describe any stepparent's personality and attitude toward you (past and present):

Please describe your relationship with your siblings (if any)(past and present):

In what ways were you punished by your parents/guardians as a child?

Describe the atmosphere of the home in which you grew up. How did your parents get along with each other? With the children?

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

Have any close relatives had marital difficulties or been divorced? If so, who, and do you know what the issues were?

What deaths, losses (including miscarriages), or separations have you experienced in your family?
What were your feelings and how did you cope with them?

Is there anyone else living in your home that you have not listed above?

Do you live in a house, apartment, etc.?

Section 4: Current and Past Problems

Current Problems

Please describe the key problems for which you are currently seeking treatment. Please discuss when it started, length of time, any specifics you consider important, why you are coming now, etc. Feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

Are there any other environmental factors that contribute to your difficulties (e.g., financial difficulties)?

Are there any other difficulties you've experienced?

Do you have some idea how these problems developed?

Section 5: Your Social Environment

Who are the most emotionally supportive people in your life?

How would you describe your friendship network? Do you have friends you feel close to? Do they live locally?

Do you consider yourself to be spiritual or religious?

If yes, please describe your faith or beliefs

What are typical things you do for pleasure or enjoyment, and how often?

Section 6: Medical and Mental Health History

Please describe your current physical health:

Please describe any significant past medical problems and treatments (e.g., illnesses, surgeries, accidents, etc.):

Do you exercise regularly? If so, how often and what type of exercise?

If you are not currently exercising, is it something that is important to you?

Do you currently have a primary care physician?

Primary Care Physician's Name, Address, and Phone (if applicable):

Do you wish to have your primary care physician contacted or involved in your mental health treatment?

Please list any psychiatric and non-psychiatric medications you are currently taking using the categories below:

Psychiatric:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>
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Nonpsychiatric:

<u>Medication</u>	<u>Dosage</u>	<u>Reason for taking</u>
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Who currently prescribes your psychiatric medications?

Which psychiatric medications have you been on in the past, if any?

Please let me know if you would like me to consult with your medication prescriber at any point in treatment.

Please describe your past experiences in outpatient therapy as best as you can remember, if any:

Therapist Name	Dates of treatment (start & end dates)	Approx. # of sessions	Type of treatment (individual, etc.)	Reason for seeking treatment
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Please describe your past experiences in inpatient or day hospital programs, if any:

Facility/program	Dates of treatment (start . end dates)	Type of program	Reasons for seeking treatment
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Were you sexually, physically, or emotionally abused at any point in your life?

Have you had any other significant life changing events or traumas that have affected you?

Does anyone in your family (immediate and extended) struggle with mental illness? If so, please describe

When you are feeling distressed (e.g. anxious, depressed, stressed, sad, overwhelmed, etc.), how do you typically cope/help yourself feel better?

Section 7: History of Suicidal Feelings

Many people think about suicide on occasion. Have you had times in life where you were thinking a lot about suicide? If so, please briefly describe when, what seemed to be triggering the thoughts, and whether you made a suicide attempt or a suicidal gesture.

Section 8: Other Symptoms

How is your concentration?

How is your memory?

How is your appetite?

Have you gained or lost weight recently?

Is your appetite affected by emotional issues?

Have you had or do you currently have any issues with eating (bulimia, anorexia, etc.)? If so, when?

Do you have trouble falling asleep?

Do you wake up frequently during the night?

Do you wake up earlier in the morning than you would like?

Approximately how many hours of sleep do you get per night?

Are there any sexual issues that cause you concern?

Sexual interest is often affected by emotional issues and medications. Do you struggle with issues related to sexual interest?

Section 9: Substance Use and Addictive Behaviors

How often and how much do you drink alcohol? When? Where?

Do you believe your alcohol use may be a problem?

Do you believe you have ever had a problem with alcohol use? If so, when?

How often and how much do you use other non-prescribed drugs?

Do you believe your drug use may be a problem?

Do you believe you have ever had a problem with drug use? If so, when?

Do you struggle with other addictive behaviors such as using tobacco, gambling, pornography, food, etc.?

Has anyone in your family had an alcohol or drug problem? Who?

Section 10: Childhood and School Experience

Where were you born and raised?

How would you describe your childhood?

What was your school experience like? What were your relationships with peers like?

Section 11: Self Image

As you see yourself, what are your strengths?

What are your faults or weaknesses?

What would you most like to change about yourself?

Section 12: Therapy Goal & Other Things I Should Know

What would you like to accomplish out of your time in therapy?

Please describe anything else that is important to know in understanding your life and your difficulties.

What feelings have you had while filling out this questionnaire?

Thank you for completing this questionnaire. It will be very helpful in developing an organized and effective treatment plan.