

PERSONAL INFORMATION

NAME _____ AGE _____ DATE Completed _____

Briefly describe your concerns, problems, and what happened that made you decide to seek counseling at this time:

WHEN did these concerns begin? _____

Do you believe that any unresolved past experiences may be influencing what is happening now? Yes No

List **3** goals you have for treatment - what types of behaviors or changes would occur that would let you know treatment has helped you in a **POSITIVE** way?

- 1.
- 2.
- 3.

Mark ANY of the following symptoms you may be experiencing:

- | | | |
|--|---|--|
| <input type="checkbox"/> Change in sleep <ul style="list-style-type: none"><input type="checkbox"/> Trouble falling asleep<input type="checkbox"/> Early morning awakenings<input type="checkbox"/> Sleeping more than usual | <input type="checkbox"/> Tension in muscle, unable to relax | <input type="checkbox"/> Overspending |
| <input type="checkbox"/> Change in appetite/ weight <ul style="list-style-type: none"><input type="checkbox"/> Increase or gain<input type="checkbox"/> Decrease or loss | <input type="checkbox"/> Tingling or numbness in hands or feet | <input type="checkbox"/> Increase in smoking |
| <input type="checkbox"/> Problems concentrating | <input type="checkbox"/> Dizziness or light headed | <input type="checkbox"/> Increase in drinking |
| <input type="checkbox"/> Want to avoid being with others | <input type="checkbox"/> Rapid heart beat or chest pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Lack of pleasure in what used to enjoy | <input type="checkbox"/> Shakiness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Loss of energy, tired | <input type="checkbox"/> Feeling loss of control | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Change in sexual performance or interest <ul style="list-style-type: none"><input type="checkbox"/> Decrease<input type="checkbox"/> Increase<input type="checkbox"/> Dissatisfaction | <input type="checkbox"/> Increase worry <ul style="list-style-type: none"><input type="checkbox"/> About the future<input type="checkbox"/> About the past | <input type="checkbox"/> Stomach distress |
| <input type="checkbox"/> Thoughts of not wanting to live | <input type="checkbox"/> Increase in negative thoughts about self | <input type="checkbox"/> Problems with vision |
| <input type="checkbox"/> Increased feelings of sadness or crying | <input type="checkbox"/> Increase in fears | <input type="checkbox"/> Problems with hearing |
| | <input type="checkbox"/> Increase in irritability or anger | <input type="checkbox"/> High blood pressure |
| | <input type="checkbox"/> Swings in mood | <input type="checkbox"/> Change in work performance <ul style="list-style-type: none"><input type="checkbox"/> Not as efficient<input type="checkbox"/> Distractible<input type="checkbox"/> Disagreements<input type="checkbox"/> Absence<input type="checkbox"/> Tardiness |
| | <input type="checkbox"/> Feeling that something bad is going to happen | |

MEDICAL HISTORY AND PRIOR MENTAL HEALTH TREATMENT

Physician's Name _____ City _____

Date of Last Physician Contact or Physical Exam (Month/Year) _____

List any major illnesses, surgeries, and hospitalizations - note age at which it occurred:

Are you **currently** under a physician's care? No Yes, For What? _____

ALLERGIES (Medication & Environmental): _____

List any **CURRENT MEDICATIONS:**

MEDICATION EFFECTS	DOSAGE	STARTED (month/year)	SIDE
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			<input type="checkbox"/> NO <input type="checkbox"/> YES
			<input type="checkbox"/> NO <input type="checkbox"/> YES

MENTAL HEALTH SERVICES: Identify who in your family has received mental health services in the past including yourself? _____

Name of Provider _____

When (Month/Year) _____ Was this experience helpful to you? Yes No

Please list immediate and extended family members who have experienced problems with depression, anxiety, emotional problems, alcoholism, or drug abuse.

EDUCATION AND EMPLOYMENT HISTORY

What is the highest grade or degree completed: _____

- Did you experience **difficulties** in any of the following in school (mark all that apply): Concentrating
- Reading Organization Motivating Remembering information you heard Taking tests
- Taking time to plan ahead Completing work Self control

Who is your **current employer** ? _____

How long have you worked with this employer? _____

Type of work you currently do _____

Are you presently experiencing any problems performing your job duties? No Yes
If yes, what changes would you like to see? _____

Prior employment _____

FAMILY INFORMATION

Spouse's Name _____ Age _____ Occupation _____
or **Significant Other's**

CHILDREN AND STEPCHILDREN:

Name _____ Age _____ Grade/Occupation _____

Name _____ Age _____ Grade/Occupation _____

Name _____ Age _____ Grade/Occupation _____

Name _____ Age _____ Grade/Occupation _____

FAMILY HISTORY:	Age	Occupation	City where lives	If deceased, YEAR

Mother

Father

Sibling

Sibling

Sibling

Sibling

Current Marital Status:

- Single
- Married Length of marriage: _____
- Divorced Month/year it occurred: _____
- Separated Length of separation: _____
- Widowed Year of spouse's death: _____
- Prior marriages, _____ (number)

Are you satisfied in the relationship with your spouse or significant other? No Yes
If not, what changes would you like to see _____

SOCIAL

How do you enjoy spending your leisure time? _____

Do you enjoy reading? Yes No How many hours of television do you watch a week? _____

Does your current financial situation play a significant factor in the stress you experience? Yes No

Is spirituality/religion important in your life? No Yes

Would you like to see any changes in this area? No Yes

Are you **satisfied in your relationship(s) with:**

your children or stepchildren? Yes No Not apply

your stepchildren? Yes No Not apply

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your parents? Yes No Not apply

your siblings? Yes No Not apply

your friends? Yes No

If you are not satisfied with any of the above, what type of changes would you like to see? _____

PERSONAL LIFE

Do you use alcohol? No Yes, Beer Wine Mixed Drinks

Amount (per week or month) _____

Have you ever had any negative experiences as a result of drinking (DWI, fights, conflict with family, financial problems, etc.) No Yes What was the substance? _____

How long ago? _____ How many experiences? _____

Have you ever **ABUSED** alcohol, prescription or non-prescription drugs? No Yes- When/What? _____

In the past month have you ever felt you ought to cut down on your drinking or drug use? No Yes

In the past month have you ever felt annoyed by people criticizing your drinking or drug use? No Yes

In the past month have you felt bad or guilty about your drinking or drug use? No Yes

Do you currently smoke? No Yes For HOW long _____ Current amount (packs) _____

Do you exercise regularly? No Yes Are you satisfied with your current level? No Yes

Have you ever been physically, sexually, or verbally abused by anyone? No Yes

Who _____ How long ago _____

Have you ever seriously thought about suicide or wanting to die? No Yes How long ago _____

Have you ever made a suicide attempt? No Yes - How & When _____

Have you ever seriously threatened or physically harmed another person? No Yes-Who/When? _____

STRESSORS Mark all **you** or a **family member**(spouse or child) have experienced in the **Past Two Years**.-

Marriage Remarriage Involvement in a serious relationship

Divorce Separation

Increase in arguments: children stepchildren spouse _____

Change in relationship with parents: improvement deterioration

