

INDIVIDUAL QUESTIONNAIRE

The information you give in this questionnaire is strictly confidential. Please fill it out as thoroughly as possible. This will assist us in the process of identifying your concerns and your goals for therapy.

Name: _____

Date: _____

Your age: _____

Date of Birth: ____/____/____

Current Problems

Check the items that describe or relate to the concerns you have now:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bereavement (grief) | <input type="checkbox"/> Illness of other | <input type="checkbox"/> Loss of faith in self |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fear | <input type="checkbox"/> Loss of faith in others |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-doubt | <input type="checkbox"/> Loss of hope |
| <input type="checkbox"/> Panic | <input type="checkbox"/> Intense Anger | <input type="checkbox"/> Loss of meaning |
| <input type="checkbox"/> Career Issues | <input type="checkbox"/> Insecurity | <input type="checkbox"/> Loss of self-respect |
| <input type="checkbox"/> Relationship with authorities | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Loss of love |
| <input type="checkbox"/> Work stress | <input type="checkbox"/> Guilt | <input type="checkbox"/> Religious or spiritual concerns |
| <input type="checkbox"/> Marriage or Partner Problems | <input type="checkbox"/> Unusual feelings or thoughts | <input type="checkbox"/> Personal fulfillment |
| <input type="checkbox"/> Relationship w/parents | <input type="checkbox"/> Suicidal feelings or thoughts | <input type="checkbox"/> Spiritual Development |
| <input type="checkbox"/> Relationship w/children | <input type="checkbox"/> Infidelity of self | <input type="checkbox"/> Anger with God |
| <input type="checkbox"/> Relationship w/in-laws | <input type="checkbox"/> Infidelity of spouse | <input type="checkbox"/> Loss of faith in God |
| <input type="checkbox"/> Relationship w/other | <input type="checkbox"/> Sexual desire | <input type="checkbox"/> Sleep difficulty |
| <input type="checkbox"/> Illness of self | <input type="checkbox"/> Sexual identity | <input type="checkbox"/> Troubled dreams |
| | <input type="checkbox"/> Sexual orientation of self or other | <input type="checkbox"/> Alcohol |
| | | <input type="checkbox"/> Drugs |
| | | <input type="checkbox"/> Other _____ |

What are your reasons for seeking counseling? _____

These Problems have existed for (time): _____

Since they started, have your problems: Stayed the same?
 Worsened?
 Lessened?

What are the causes of your problems? _____

What are the main concerns you want to work on in therapy?

1. _____ 2. _____

3. _____ 4. _____

Your problems would improve if: _____

Do you believe that you can be helped? Yes No

How would you like your life to be five years from now? _____

	Poor	Fair	Avg.	Good	Excellent
Your physical condition is:	___	___	___	___	___
Your emotional condition is:	___	___	___	___	___
Your spiritual condition is:	___	___	___	___	___

Personal Data

When you were born, were there any complications that you are aware of? Yes No

If yes, explain: _____

Were you adopted or raised by someone other than biological parent(s)? Yes No

Describe your earliest memory: _____

Check any of the following childhood experiences which apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Robust health | <input type="checkbox"/> Daydreaming | <input type="checkbox"/> Early talking |
| <input type="checkbox"/> Early walking | <input type="checkbox"/> Special skills | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Special interests | <input type="checkbox"/> Sensitive awareness | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Confident mood | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Excessive fighting |
| <input type="checkbox"/> Repeated nightmares | <input type="checkbox"/> Shyness | <input type="checkbox"/> Slow physical dev. |
| <input type="checkbox"/> Night terrors | <input type="checkbox"/> Eagerness to learn | <input type="checkbox"/> Bowel problems/
bedwetting |
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Overweight | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tics | <input type="checkbox"/> Slow talking | |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Fear of playmates | |
| <input type="checkbox"/> Stuttering | <input type="checkbox"/> Imaginary playmates | |

Please describe any distressing situation you have not been previously mentioned:

Briefly describe yourself as a person:

Family History

Please complete "family data" on page 11 before completing this section.
(Throughout this questionnaire, where mother or father is mentioned, you may add primary caregiving figures, if appropriate).

How would you describe your family when you were growing up?

How would you describe your family or living unit now? _____

Briefly describe your mother: _____

Briefly describe your father: _____

Who was your primary caregiver? If not a parent, please explain. _____

How were you disciplined, by whom, for what behavior, how often? _____

Are your parents divorced or separate? Yes No

If yes, how old were you, what were the circumstances and how did you react?

Who initiated the divorce or separation? _____

With which parent did you live? _____
 Did this parent remarry? ___ Yes ___ No How old were you? _____
 Did the other parent remarry? ___ Yes ___ No How old were you? _____

List any people not listed on the Family Data Page who are living in your house (give name, age and relationship). _____

Have you lost a family member or someone close through death? ___ Yes ___ No
 If yes, whom did you lose, how old were you at the time, how did this person(s) die, and how did you react? _____

Have any members of your family been involved in psychotherapy, received medication or been hospitalized for emotional difficulties? ___ Yes ___ No
 If yes, please describe each: _____

Medical History

Complete the following check-list of physical concerns by circling "R" for Regularly, "O" for Occasionally, "S" for Seldom, and "N" for Never.
 Please circle a letter for each item.

- | | | | |
|---------|-----------------------|---------|--------------------------|
| R O S N | Nervousness | R O S N | Sleeping difficulties |
| R O S N | Chest pains | R O S N | Underweight |
| R O S N | Clenching of jaw | R O S N | Exaggeration of appetite |
| R O S N | Exhaustion | R O S N | Sinus congestion |
| R O S N | Colds/flu | R O S N | Shortness of breath |
| R O S N | Allergies | R O S N | High blood pressure |
| R O S N | Muscle tension/cramps | R O S N | Nausea |
| R O S N | Overweight | R O S N | Loss of appetite |
| R O S N | Headaches | R O S N | Heart racing |
| R O S N | Skin Problems | R O S N | Drug dependence |
| R O S N | Chronic pain | R O S N | Cold hands/feet |
| R O S N | Persistent cough | R O S N | Colitis |
| R O S N | Sexual difficulties | R O S N | Migraine headaches |
| R O S N | Lack of sexual desire | R O S N | Grinding teeth |
| R O S N | Problem with erection | R O S N | Other _____ |
| R O S N | Indigestion | | |

Your height: _____ Weight: _____ Any recent changes in weight? Yes No
If yes, explain: _____

When was your last physical examination? _____ Purpose? _____
Results? _____

List outstanding or unusual diseases or illnesses you have had and your age at the time:

List all current medication and reason for taking: _____

Are there any hereditary diseases in your family? Explain: _____

Do you have any physical impairments, scars, or disfigurements, which concern you?
 Yes No If yes, explain: _____

Age at the onset of puberty/menstrual periods _____ Concerns, if any, you had about
puberty/menstrual periods _____

If you have been pregnant or fathered a child, were there any concerns/problems related to
the pregnancy(s) or birth(s)? Yes No If yes, please explain _____

Sexual History

What were your parents' attitudes toward sex? _____

How was sex discussed in your family when you were young? _____

When, how, and from whom did you first learn about sex? _____

Have you had an unusual, unpleasant or frightening sexual experience? Yes No
If yes, please explain: _____

Are you generally satisfied with your sex life? Yes No

What changes, if any, would you like in your sex life? _____

Relational History

Single Married Committed Relationship Duration

If married, length of engagement _____

Please describe your current relationship status _____

Please list other marriages/committed relationships (give information for each)

Name of Spouse/Partner _____

Date of marriage/committed relationship: _____ Termination date: _____

Reason: _____ Death _____ Divorce _____ Other

Names of children of this marriage/relationship _____

Name of Spouse/Partner _____

Date of marriage/committed relationship: _____ Termination date: _____

Reason: _____ Death _____ Divorce _____ Other

Names of children of this marriage/relationship _____

Other partner relationships: (Describe when begun, how progressed, when and how ended)

Religion and Spirituality

Do you identify yourself with a religious group? Yes No

If yes, which: _____

Does your spouse or partner? Yes No

If yes, which: _____

If not, do you have a spiritual concept or belief? ___ Yes ___ No If yes, please describe:

Do you attend religious services or have a spiritual practice? ___ Yes ___ No

Do you participate ___ Regularly ___ Occasionally ___ Never

Mother's religion or belief: _____ Father's: _____

What part did religion or spirituality play in your growing up? _____

What part does religion or spirituality play in your life now? _____

Do you come with any specifically religious or spiritual concerns? ___ Yes ___ No

If yes, please explain: _____

What goals, dreams or purpose do you see for your life? _____

School History

Briefly describe your school experience: _____

Age started: _____ Last grade or credential completed: _____

Number of elementary and secondary schools attended: _____

Were you ever in special classes? ___ Yes ___ No If yes, please explain: _____

What extracurricular interests and activities did you engage in? _____

Did you have other special difficulties or problems in school? ___ Yes ___ No

If yes, please explain: _____

Did you have other satisfactions or achievements in school? If yes, please explain: _____

Occupational History

List brief history of employment beginning with current or most recent job(s):

Where Employed	Type of work	How long	Reason for leaving
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Number of jobs in past years: _____ Were you ever fired? ___ Yes ___ No

If yes, why? _____

What was the longest job you've held and how long did you hold it? _____

Has your job situation changed in the last five years? ___ Yes ___ No If so, how? _____

Over the past five years, has your financial status: ___ improved
___ worsened
___ stayed the same

Are you satisfied with your current job(s)? ___ Yes ___ No Please explain: _____

Legal Information

Check any current or past legal problems:

___ Driving offenses ___ Financial ___ Family
___ Fights ___ Other _____

Please explain: _____

Have you been arrested or imprisoned? ___ Yes ___ No. If yes, please explain: _____

Are you currently involved in any pending legal action? ___ Yes ___ No If yes, please explain: _____

Alcohol And/Or Other Chemical Use

Please complete the following by inserting the appropriate information and circling the appropriate frequency code. Please fill out each item.

1= Daily 2= Weekly 3= Monthly
 4= Occasionally 5= Seldom 6= Never

	Age first Used	Age Last Used	Frequency	Daily Dosage/ Quantity
Tobacco	_____	_____	1 2 3 4 5 6	_____ packs
Caffenine	_____	_____	1 2 3 4 5 6	_____ cups
Alcohol	_____	_____	1 2 3 4 5 6	_____ drinks
Tranquilizers	_____	_____	1 2 3 4 5 6	_____
Sleeping pills	_____	_____	1 2 3 4 5 6	_____
Weight reducing pills	_____	_____	1 2 3 4 5 6	_____
Speed	_____	_____	1 2 3 4 5 6	_____
Narcotics	_____	_____	1 2 3 4 5 6	_____
Street drugs	_____	_____	1 2 3 4 5 6	_____
Marijuana/hashish	_____	_____	1 2 3 4 5 6	_____
Cocaine	_____	_____	1 2 3 4 5 6	_____
Hallucinogens	_____	_____	1 2 3 4 5 6	_____
Other _____	_____	_____	1 2 3 4 5 6	_____

Does the use of the above items interfere with your home life, social life, work or school life?
 ___ Yes ___ No If yes, please explain: _____

Does the use of the above items by anyone close to you interfere with your home life, social life, work or school life? ___ Yes ___ No If yes, please explain: _____

Do you have "after effects" from your uses of alcohol or drugs? ___ Yes ___ No If yes, please explain: _____

Are you regularly using any non-prescription medications? ___ Yes ___ No If yes, please list: _____

Are you regularly using any health or nutritional supplements? ___ Yes ___ No If yes, please explain: _____

Social Information

In your opinion, what do other people think of you? _____

Would you like to change your social life? If so, how? _____

* * * * *

Is there any additional information about yourself that would help us to understand you as a person? _____

FAMILY DATA

(Include relatives whether living or dead)
 (If deceased, give approximate date of death)

	Name	Age	Sex	Living or Deceased	Marital Status	Occupation	Town and State
Spouse							
Children							
Parents							
Father							
Mother							
Other							
Siblings							