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:

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

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

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 <u>not</u> 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.
<u>Please circle a letter for each item.</u>

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							