The purpose of this questionnaire is to gather a well rounded understanding of your life experience and background. Completing these questions fully and accurately will benefit you through the development of a treatment program for your specific needs.

Date: _____

Name:_____

Addres:_____

Phone: Home~_____Work~_____Cell~_____

Date of Birth_____ Age_____

Emergency Contact Person:_____Phone_____

Highest level of education:_____

Relationship Status: ___Single ___Engaged ___Married ___Separated ___Divorced ___Widowed

___Remarried ___Committed Relationship

Sexual Orientation: ___Heterosexual ___Gay ___Lesbian ___Bisexual ___Transgendered

Ethnic/ Cultural Background:_____

Current Employment: _____

Position:_____ Unemployed?_____

Military?_____ Branch_____ Combat Exposure?_____

Medical History

1. Family Doctor and Phone #:_____
2. Last Physical Exam:_____
3. Are you taking medications? ___ yes ___no

   If so, what medication and why:

   _____

   _____
4. Are you currently experiencing medical problems?

   _____

   _____

5. Have you ever been hospitalized for an emotional or mental illness?

   _____

6. How often do you use alcohol or drugs? ____Not at all ___less than once a week ___ more than once per week ____Once per day typically. Which ones?_____

7. Has your use of alcohol or drugs impaired any of the following: __work functioning ___health ___finances ___your relationships ___other

8. My relationship with food is_____

9. How often are you able to get physical exercise _____

10. **For Women only:**
    Number of Births:_____Abortions:_____ Miscarriages:_____ Stillbirths:____IVF treatments:_____

    Are you pregnant?_____ Are you menopausal?_____

Emotional History

1. Have you been to a counselor before?_____
2. If yes, When?_____ Cause:_____
3. Counselor name_____
4. Treated for any specific issue?_____
5. Were you satisfied with your experience? _____
6. Reason for seeking counseling at this time?

7. How long have you been experiencing this difficulty? _____
8. What kinds of things have you done in the past to deal with problems?

9. Prior to the problem you are working on now, how would you describe your emotional make-up?

   Extremely stable Average Struggled more than others Always struggling

10. Have you ever considered suicide? ___Yes ___ No When? _____
11. Have you ever experimented with cutting? ___ Yes ___ No

Spirituality: *For many of our clients, spirituality may be a strong part of their identity and source of strength that they would like to include in their counseling process. This is not the case for all.*

1. What does spirituality mean to you?

2. Have your religious or spiritual experiences helped or hurt your ability to deal with struggles?

3. Do you affiliate with a specific belief, faith, denomination or religion? __ Yes __ No
   If yes, which one:_____

Family of Origin:

Briefly describe the way it felt growing up in your childhood home(s). Please include the relationship between your parents and the relationship between parents and children.

Describe your father's personality and how he treated you.

Describe your mother's personality and how she treated you.

Describe how many siblings you have, your birth order, and your relationship with them.

Describe any turning points or significant events that impacted you (i.e. Divorces, deaths, abuse, Moving homes, switching schools, injury/illness, school relationships, accidents):

Family history of alcoholism or drug use?_____

Present Family:

1. Name and age of Spouse/ Partner_____
2. How long have you been together? _____
3. How would you characterize your current home life?
   __ extremely stable __generally stable __average __ we struggle more than others __always struggling
4. List anyone who lives in your home with you_____
   _____
5. Any concerns about the care and/or safety of your children?_____

6. What do you enjoy most about your current family situation?

Present Situation:

1. Please check any present behaviors you or others consider problematic & explain
   - ☐ Depression
   - ☐ Job Stress
   - ☐ Panic Attacks
   - ☐ Crying Spells
   - ☐ Decreased Activity
   - ☐ Fear of Dying
   - ☐ Mood Swings
   - ☐ Racing Thoughts
   - ☐ Loneliness
   - ☐ Emptiness
   - ☐ Increase or Decrease in Appetite
   - ☐ Guilt/Shame
   - ☐ Sexual Problems
   - ☐ Isolation
   - ☐ Not seeing friends
   - ☐ Sleeping Increase or Decrease
   - ☐ Nightmares
   - ☐ Poor concentration
   - ☐ Nervous/Anxious
   - ☐ Financial Worries
   - ☐ Relationship Breakup
   - ☐ Relationship Problems
   - ☐ Increased Alcohol Use
   - ☐ Blackouts
   - ☐ Increased Drug Use
   - ☐ Withdrawal Symptoms
   - ☐ Feeling Controlled
   - ☐ Hearing Voices
   - ☐ Seeing Things Others Don't
   - ☐ Unusual Thoughts
   - ☐ Confusion

Are there any other present emotions or feelings you or others consider problematic that we missed?

2. List any <u>specific</u> thoughts, images, dreams, or fantasies that you or others consider problematic that would be helpful

3. Is your counseling court ordered? _____

4. Are you on probation or parole? ____Yes ____ No _____

5. Have you ever Been Arrested? ____ Yes ____No _____

6. Have you ever been sexually, physically, emotionally, or verbally abused? __yes __no
   If yes, please explain:

7. Do you have any history of domestic violence? ___Victim ___Perpetrator
8. Do you have any history of an Eating Disorder? ___Yes ___ No

In the past year have you experienced:

Loss of an immediate family member?	__ No	__ Yes _____
Loss of a close friend or loved one?	__ No	__ Yes _____
Divorce or separation from partner?	__ No	__ Yes _____
Loss of job or opportunity?	__ No	__ Yes _____
Significant family conflict?	__ No	__ Yes _____
Is your family supportive?	__ No	__ Yes _____
Do you have a support system in place?	__ No	__ Yes _____

Counseling Goals:

What are your goals and expectations from counseling?

What are your greatest strengths?

Is there anything else I should know about you?