

PURPOSE OF THIS QUESTIONNAIRE:

The purpose of this questionnaire is to obtain a comprehensive picture of your background. In psychotherapy, records are necessary since they are more thorough dealing with one’s problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time. It is understood that you might be concerned about what happens to the information about you because much or all this information is highly personal. Case records are strictly confidential. NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORDS WITHOUT YOUR PERMISSION.

If you do not desire to answer any questions, merely write “DO NOT CARE TO ANSWER.”

Date: _____

1. General Information:

Name: _____

Address: _____

Telephone Numbers: (days) _____ (evenings) _____

Age _____ Occupation _____ Sex _____

By whom were you referred? _____

Marital Status (circle one) Single Engaged Married Separated Divorced Widowed

Remarried (how many times? _____) Living with someone _____

Do you live in a house, hotel, room, apartment _____

2. Description of Presenting Problems:

State in your own words the nature of your main problems

On the scale below please estimate the severity of your problems.

Mildly Moderately Very Extremely Totally
Upsetting _____ Upsetting _____ Severe _____ Severe _____ Incapacitating _____

When did your problems begin (give dates):

Please describe significant events occurring at that time, or since then which may relate to the development or maintenance of your problems.

What solutions to your problems have been helpful?

Have you been in therapy before or received any prior professional assistance for your problems? If so, please give name (s), professional title (s), dates of treatments and results:

3. Personal and Social History

- (a) Date of Birth _____ Place of Birth _____
- (b) Siblings: Number of Brothers _____ Brothers' Ages _____
Number of Sisters _____ Sisters' Ages _____
- (c) Father: Living? _____ If alive, give father's present age _____
Deceased? _____ If deceased, give his age at time of death _____
How old were at the time? _____
Cause of Death _____
Occupation _____ Health _____
- (d) Mother: Living? _____ If alive, give mother's present age _____
Deceased? _____ If deceased, give her age time of death _____
How old were at the time? _____
Cause of Death? _____
Occupation _____ Health _____
- (e) Religion: As a child: _____ As an adult: _____
- (f) Education: What is the last grade completed (degree)? _____
- (g) Scholastic Strengths and Weaknesses: _____

Underline any of the following that applied during childhood/adolescence:

Happy Childhood School Problems Medical Problems Unhappy Childhood
Family Problems Alcohol Abuse Emotional/Behavioral Problems
Strong Religious Convictions Legal Trouble Drug Abuse Others:

- (h) What sort of work are you doing now? _____
- (i) What kind of jobs have you held in the past _____

- (j) Does your present work satisfy you? If not, please explain _____

- (k) What is your annual family income? _____
How much does it cost you to live? _____
- (l) What were your past ambitions? _____

- (m) What are your current ambitions? _____
- (n) What is your height? _____ ft. _____ inches _____ What is your weight? _____ lbs.
- (o) Have you ever been hospitalized for psychological problems? Yes _____ No _____
If yes, when and where? _____
- (p) Do you have a family physician? Yes _____ No _____ If so, please write his/her name(s) and telephone
number(s) _____
- (q) Have you ever attempted suicide? Yes _____ No _____
- (r) Does any member of family suffer from alcoholism, epilepsy, depression or anything else that might be
considered a "mental disorder"? _____
- (s) Has any relative attempted or committed suicide? _____
Has any relative had serious problems with the "law"? _____

Modality Analysis of Current Problem

The following section is designed to help you describe your current problems in greater detail and to identify problems which might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it your specific needs. The following section is organized according to the seven (7) modalities of Behavior, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships and Biological Factors.

4. Behavior

Underline any of the following behaviors that apply to you:

- | | | | |
|----------------------------|---------------------|------------------|--------------------|
| Overeat | Suicide attempts | Can't keep a job | Take drugs |
| Compulsions | Insomnia | Vomiting | Smoke |
| Take too many risks | Odd Behavior | Withdrawal | Lazy |
| Drink too much | Nervous ticks | Eating problems | Work to hard |
| Concentration difficulties | Aggressive behavior | Procrastination | Sleep Disturbance |
| Crying | Impulsive reactions | Phobic Avoidance | Outburst or temper |
| Loss of control | | | |

Are there any specific behaviors, actions or habits that you would like to change?

What are some special talents or skills that you feel proud of?

What would you like to do more of? _____

What would you like to less off? _____

What would you like to start doing? _____

What would you like to stop doing? _____

How is your free time spent? _____

Do you keep yourself compulsively busy doing an endless list of chores meaningless activities? _____

Do you practice relaxation or meditation regularly?

What pictures comes into your mind most often?
Describe a very pleasant image, mental picture, or fantasy.

Describe your image of a very "safe place."

How often do you have nightmares?

5. Thoughts

Underline each of the following thoughts that apply to you:

I am worthless, a nobody, useless and/or unlovable.

I am unattractive, incompetent, stupid and/or undesirable.

I am evil, crazy, degenerate and/or deviant.

Life is empty, waste, there is nothing to look forward to.

I make too many mistakes, can't do anything right.

Underline each of the following words that you might use to describe yourself:

Intelligent, confident, worthwhile, ambitious, sensitive, loyal, trustworthy, full of regrets, worthless, a nobody, useless, evil, crazy, morally degenerate, a deviant, unattractive, unlovable, inadequate, confused, ugly, stupid, naïve, honest, incompetent, horrible thoughts, conflicted, concentration difficulties, memory problems, attractive, can't make decisions, suicidal ideas, persevering, good sense of humor, hard-working.

What do you consider to be your most irrational thought or idea?

Are you bothered by thoughts that occur over and over again?

On each of the following items, please circle the number that accurately reflects your opinions:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I should not make mistakes	1	2	3	4	5
I should be good at everything I do	1	2	3	4	5
When I do not know I should pretend That I do	1	2	3	4	5
I should disclose personal information	1	2	3	4	5
I am a victim of circumstance	1	2	3	4	5

Give a description of your father's personality and his attitude toward you (past and present)

Give a description of your mother's (or mother substitute) personality toward you (past and present)

In what ways were you disciplined (punished) by your parents as a child

Give an impression of your home atmosphere (i.e., the home in which you grew up).

Mention state of compatibility between parents and children.

Where you able to confide in your parents?

Did your parents understand you?

Basically, did you feel loved and respected by your parents?

If you have a step-parent, give your age when parent remarried

Has anyone (parents, relatives, and friends) ever interfered in your marriage, occupation, etc?
Who are the most important people in your life?

6. Friendships

(1) Do you make friends easily?

(2) Do you keep them

(3) Were you ever bullied or teased?

(4) Describe any relationship that gives you:

(a) Joy

(b) Grief

(5) Rate the degree to which you generally feel comfortable and relaxed in social situations

Very relaxed _____ relatively comfortable _____

Relatively uncomfortable _____ Very anxious _____

(6) Generally do you express your feelings, opinions, and wishes to others in an open, appropriate?
Describe these:

7. Relationships

(1) Any relevant details regarding your first or subsequent sexual experiences?

(2) Is your present sex life satisfactory?

- (3) Provide information about any significant homosexual reactions or relationships.
- (4) Please note any sexual concerns not discussed above.

Other Relationships

- (1) Are there any problems in your relationships with people at work? If so, please describe:

- (2) Please complete the following:
 - (a) One of the ways people hurt me is

 - (b) I could shock you by

 - (c) A mother should
 - (d) A father should

 - (e) A true friend should

- (3) Give a brief description of yourself as you would be described by:
 - (a) Your spouse (if married):

 - (b) Your best friend:

 - (c) Someone who dislikes you:

- (4) Are you currently troubled by any past rejections or loss of a love/relationship? If so, please explain:

8. Biological Factors

Do you have any current concerns about your physical health? Please specify

Please list any medicines you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicines that were prescribed or taken over the counter).

Do you eat three well-balanced meals a day?_____ If not, please explain:

Underline any of the following that apply to you or members of your family; thyroid disease, kidney disease, asthma, neurological disease, infectious diseases, diabetes, cancer, gastrointestinal disease, prostate problems, glaucoma, epilepsy, other

Have you ever had any head injuries or loss of consciousness? Please give details

Please describe any surgery you have had (give dates)

Please describe any accidents or injuries you have suffered (give dates)

Sequential History

Please outline your most significant memories and experiences with the following age:

0-5 _____

6-10 _____

11-15 _____

16-20 _____

21-25 _____

26-30 _____

31-35 _____

36-40 _____

41-45 _____

46-50 _____

51-55 _____

56-60 _____

61-65 _____

Over 65 _____

Do you get regular physical exercise? _____ If so, what type and how often.

Check any of the following that apply to you:

	NEVER	RARELY	FREQUENTLY	VERY OFTEN
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc.)				
Diarrhea				
Constipation				
Allergies				
High Blood Pressure				
Heart Problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backaches				
Early morning awakening				
Fitful sleep				
Overeat				
Poor appetite				

