**Laura Atterstrom M.A.**

Licensed Professional Counselor and Licensed Marriage and Family Therapist

5512 W. Plano Pkwy. Suite 300, Plano, TX 75093

laura@lauraatterstrom.com

214-868-6916

**New Client Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the main problems or symptoms that caused you to seek help now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe any stresses in your life that may have contributed to the problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the history of the problem from its onset to now:

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Have you had a similar problem in the past? \_\_ Yes \_\_ No If yes, please describe the episodes and the dates they occurred. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were you treated for this problem? \_\_Yes \_\_No If yes, please describe the treatment you received.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has this problem caused you to experience any decrease in your ability to function in the following areas?

If so, please describe:

School performance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work performance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship with spouse/significant other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Functioning as a parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ability to manage chores at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Please list all medications you are currently taking:

Prescription Medication Dose Start Date (MMYY)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mental Health History

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

Name Dates Seen Reason Medications Prescribed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever attempted suicide? \_\_Yes \_\_No If yes, please describe the nature of the event and the date(s) of occurrence. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, bi-polar disorder, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, attention deficit disorder, etc.)

Relative Problem

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Substance Use:**

Do you use any of the following?

 Substance Yes No Amount Frequency: Daily Weekly Date last used

 Tobacco \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Caffeine \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Alcohol \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Marijuana \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Cocaine \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Amphetamines \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 LSD \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Heroin \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Pain killers \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 IV Drug Use \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_ \_\_ \_\_ \_\_\_\_\_\_\_\_\_\_

 Have you ever felt that you were abusing drugs or alcohol? \_\_ Yes \_\_No If so, please describe when and the nature of the problem. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tried to stop drinking? \_\_ Yes \_\_ No If yes, what was the outcome? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attended AA? \_\_ Past \_\_ Current If yes, do you have a sponsor and how often do you attend meetings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever attended NA? \_\_ Past \_\_ Current If yes, do you have a sponsor and how often do you attend meetings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Family/Social History**

Where were you born and raised? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please list your siblings and their current ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you close to your siblings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationship with your father? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your relationship with your mother? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your childhood: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were your parents divorced? \_\_ Yes \_\_ No If yes, how old were you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom did you live after the divorce? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your mother remarry? \_\_ Yes \_\_ No Did your father remarry? \_\_ Yes \_\_ No

 What was your relationship like with the stepparent(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were you ever subjected to any type of abuse (emotional, physical, sexual)? \_\_ Yes \_\_ No

 If yes, please describe the events and ages the abuse occurred. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you lost a close family member or friend? \_\_ Yes \_\_ No Who? \_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Educational History**

Did you complete high school? \_\_ Yes \_\_ No

What kind of grades did you receive in school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you get along with your peers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you get along with your teachers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you attend college? \_\_ Yes \_\_ No

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational History**

Are you currently working? \_\_ Yes \_\_ No What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your current position? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long have you been there? \_\_\_\_\_\_\_\_

Are you satisfied with your job? \_\_Yes \_\_ No If no, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any current job stresses you may be experiencing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How well do you get along with your co-workers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How well do you get along with your supervisors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List your last two jobs and how long you worked there: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship History**

Are you currently \_\_ Single \_\_ Married \_\_ Divorced \_\_ Widowed \_\_ Living Together

How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your sexual orientation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your relationship with your spouse or significant other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any stresses or problems in your relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If married, what is your spouse’s occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been married before (or in a long-term committed relationship)? \_\_ Yes \_\_ No

How many times? \_\_\_\_\_\_\_\_ How long did these relationships last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the reason for the break-up or divorce: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have children, what are their names and ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Describe any problems you may be experiencing with your children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have religious preference? If yes what is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you attend religious services? \_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any other important information about you that has not been covered, which you feel I should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Symptom Checklist**

Check all that apply. Then circle up to 10 items that are especially bothersome to you.

 **1. Please check any of the following which may have been particularly stressful to you:**

**Recent Past**

\_\_\_ \_\_\_ Job related stress

\_\_\_ \_\_\_ Marital conflict

\_\_\_ \_\_\_ Death or loss of loved one

\_\_\_ \_\_\_ Move to a new place and losing contact with friends or family

\_\_\_ \_\_\_ Conflict with children

\_\_\_ \_\_\_ Children with behavior problems

\_\_\_ \_\_\_ Conflict with parents or extended family

\_\_\_ \_\_\_ Feeling stress due to recalling memories of trauma or stress in my life

\_\_\_ \_\_\_ Family member with an alcohol or drug problem

\_\_\_ \_\_\_ Being abused by someone

\_\_\_ \_\_\_ Financial pressure

**2. Any of the following symptoms for most of the day, nearly every day, for longer than several days at a time:**

**Recent Past**

\_\_\_ \_\_\_ Depressed or sad mood

\_\_\_ \_\_\_ Loss of interest or pleasure in things I’m normally interested in

\_\_\_ \_\_\_ Difficulty falling asleep

\_\_\_ \_\_\_ Difficulty staying asleep or waking up too early

 (avg. # of hours you are sleeping per night \_\_\_\_\_)

\_\_\_ \_\_\_ Sleeping too much

\_\_\_ \_\_\_ Increased appetite/weight gain (lbs.\_\_\_\_\_)

\_\_\_ \_\_\_ Decreased appetite/weight loss (lbs. \_\_\_\_\_)

\_\_\_ \_\_\_ Fatigue/Poor energy level

\_\_\_ \_\_\_ Decreased activity (work, social, physical, sexual)

\_\_\_ \_\_\_ Poor concentration or slowed thinking

\_\_\_ \_\_\_ Thoughts of suicide

\_\_\_ \_\_\_ Excessive feelings of guilt or worthlessness

\_\_\_ \_\_\_ Decreased sex drive or interest

**3. Any of the following symptoms, more days than not, for months at a time:**

**Recent Past**

\_\_\_ \_\_\_ Excessive anxiety or worry for no good reason

\_\_\_ \_\_\_ Trembling, twitching or feeling “shaky”

\_\_\_ \_\_\_ Muscle tension or muscle aches

\_\_\_ \_\_\_ Easily fatigued

\_\_\_ \_\_\_ Dry mouth

\_\_\_ \_\_\_ Dizziness or lightheadedness

\_\_\_ \_\_\_ Nausea, diarrhea or other stomach problems

\_\_\_ \_\_\_ Frequent urination

\_\_\_ \_\_\_ Feeling keyed up or on edge

\_\_\_ \_\_\_ Irritability

\_\_\_ \_\_\_ Trouble falling or staying asleep

**4. Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:**

**Recent Past**

\_\_\_ \_\_\_ Panic attacks/anxiety attacks

\_\_\_ \_\_\_ Persistent worry that I will have a panic attack

\_\_\_ \_\_\_ Heart pounding or racing heart

\_\_\_ \_\_\_ Trembling or shaking

\_\_\_ \_\_\_ Sweating

\_\_\_ \_\_\_ Choking

\_\_\_ \_\_\_ Nausea or stomach problems

\_\_\_ \_\_\_ Feelings of unreality

\_\_\_ \_\_\_ Numbness or tingling sensations

\_\_\_ \_\_\_ Feeling of smothering or shortness of breathe

\_\_\_ \_\_\_ Fear of dying

\_\_\_ \_\_\_ Fear of going crazy or doing something uncontrolled

\_\_\_ \_\_\_ Chest pain or discomfort

\_\_\_ \_\_\_ Dizziness, unsteady feelings or faintness

\_\_\_ \_\_\_ Flushes, hot flashes or chills

\_\_\_ \_\_\_ Avoiding situations or places that may cause panic or severe anxiety

**5. Any of the following symptoms for most of the day, nearly every day, for more than four days at a time:**

**Recent Past**

\_\_\_ \_\_\_ Euphoric or “high” mood

\_\_\_ \_\_\_ Irritable mood

\_\_\_ \_\_\_ Decreased need for sleep without feeling tired

\_\_\_ \_\_\_ Increased energy level

\_\_\_ \_\_\_ Increased activity (work, social, physical, sexual)

\_\_\_ \_\_\_ Thoughts speeded up or racing thoughts

\_\_\_ \_\_\_ Increased talkativeness or being much more socially outgoing

\_\_\_ \_\_\_ Making decisions too impulsively

\_\_\_ \_\_\_ Going on spending sprees

**6. Check any of the following relating to your alcohol or drug use:**

**Recent Past**

\_\_\_ \_\_\_ I’ve felt alcohol or drugs were causing a problem for me

\_\_\_ \_\_\_ I have felt guilty about my use

\_\_\_ \_\_\_ Others have annoyed me about my use

\_\_\_ \_\_\_ I have had a desire (or made unsuccessful efforts) to cut down or control my use

\_\_\_ \_\_\_ I’ve tried unsuccessfully to control my use

\_\_\_ \_\_\_ I’ve used alcohol or drugs more often or in larger amounts than I intended

\_\_\_ \_\_\_ I’ve had to increase my use of alcohol or drugs to get the desired effect

\_\_\_ \_\_\_ I’ve had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I’ve cut down or stopped using alcohol or drugs

\_\_\_ \_\_\_ I’ve been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

**7. Any of the following disturbances in eating or maintaining normal weight:**

**Recent Past**

\_\_\_ \_\_\_ Insistence on maintaining body weight below expected for age and height

\_\_\_ \_\_\_ Intense fear of gaining weight or becoming fat even though underweight

\_\_\_ \_\_\_ I feel “fat” even when others see me as underweight

\_\_\_ \_\_\_ Eating binges

\_\_\_ \_\_\_ Feeling of lack of control of eating during eating binges

\_\_\_ \_\_\_ Vomiting or using laxatives to prevent weight gain

\_\_\_ \_\_\_ Being over-concerned about body weight and shape

**8. Check any of the following that apply:**

**Recent Past**

\_\_\_ \_\_\_ I tend to do things on impulse which end up being damaging to me or others

\_\_\_ \_\_\_ I have mood swings (depression, irritability, anger) lasting up to several hours

\_\_\_ \_\_\_ I have tried to commit suicide

\_\_\_ \_\_\_ I have made cuts, burns or other injuries to myself without wanting to kill myself

\_\_\_ \_\_\_ My relationships always seem to work out wrong

\_\_\_ \_\_\_ My mood often shifts from being either overconfident to having low self esteem

\_\_\_ \_\_\_ I have a hard time sympathizing with other’s pain

\_\_\_ \_\_\_ I often feel others do not understand me

\_\_\_ \_\_\_ I tend to get very hurt or angry when I am criticized or rejected by someone

\_\_\_ \_\_\_ I tend to need a lot of reassurance or approval from others

\_\_\_ \_\_\_ I am very concerned about my appearance

\_\_\_ \_\_\_ Others often expect too much of me

**9. Any of the following at any time:**

**Recent Past**

\_\_\_ \_\_\_ Hearing voices that sound real even though they are not actually there

\_\_\_ \_\_\_ Vivid voices in my head that do not seem like my ideas

\_\_\_ \_\_\_ Feeling that others might be putting thought in my head

\_\_\_ \_\_\_ Feeling others might be able to read my thoughts

\_\_\_ \_\_\_ Others feel I am too suspicious or paranoid

\_\_\_ \_\_\_ Feeling others might be talking about me

**10. Any of the following problems relating to a past severe trauma or stress:**

**Recent Past**

\_\_\_ \_\_\_ I had an experience so traumatic that nearly anyone would have been stressed by it

\_\_\_ \_\_\_ History of relatives hurting me physically or touching me in sexual areas

\_\_\_ \_\_\_ History of unwanted sexual contact

\_\_\_ \_\_\_ I have memories, dreams of a stressful event that I have trouble putting out of my head

\_\_\_ \_\_\_ I have flashbacks of past events; or I feel as though I am re-living a stressful past event

\_\_\_ \_\_\_ I try to avoid situations or people that remind me of a stressful event in the past

**11. Any of the following obsessions or compulsions:**

**Recent Past**

\_\_\_ \_\_\_ Excessive doubting; or repeated, unreasonable thoughts, images, I can’t get out of mind

\_\_\_ \_\_\_ Urges to check thing, wash things, or count repeatedly

\_\_\_ \_\_\_ Excessive concern about coming into contact with germs or dirt

\_\_\_ \_\_\_ Excessive concern with right/wrong or morality

\_\_\_ \_\_\_ Excessive need for things to be exact or symmetrical