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PERSONAL QUESTIONNAIRE

The information provided 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: _______________ Age: _______ DOB: ___________

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
- □ 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 _______________________
  ____

What are your reasons for seeking counseling: ____
____
____

These problems have existed for how long (amount of 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. ______________________________ 3. ________________________________

2. ______________________________ 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
If yes, explain: ____

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
□ Crying spells
□ Slow talking
□ Daydreaming
□ Special skills
□ Sensitive awareness
□ Learning problems
□ Shyness
□ Eagerness to learn
□ Overweight
□ Underweight
□ Fear of playmates
□ Early talking
□ Sleepwalking
□ Nail biting
□ Excessive fighting
□ Slow physical development
□ Bowel problems/bedwetting
□ Tics
□ Stuttering
□ Imaginary playmates
□ Other ____

Please describe any distressing situation(s) you have previously mentioned: ______________________

____

____

Briefly describe yourself as a person: ____

____

____

____

____

Family History

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							
Child							
Child							
Child							
Child							
Child							
Child							
Parents							
Father							
Mother							
Step Father							
Step Mother							
Sibling							
Sibling							
Sibling							
Sibling							
Sibling							
Sibling							

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 separated? □ 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 chart on the previous 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 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/	R	O	S	N	Nausea
				cramps	R	O	S	N	Loss of appetite
R	O	S	N	Overweight	R	O	S	N	Heart racing
R	O	S	N	Headaches	R	O	S	N	Drug dependence
R	O	S	N	Skin problems	R	O	S	N	Cold hands/feet
R	O	S	N	Chronic pain	R	O	S	N	Colitis
R	O	S	N	Persistent cough	R	O	S	N	Migraine headaches
R	O	S	N	Sexual difficulties	R	O	S	N	Grinding teeth
R	O	S	N	Lack of sexual	R	O	S	N	Indigestion
				desire	R	O	S	N	Other: ____________________
R	O	S	N	Problem w/erection					________________________

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, 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 □ Separated □ Divorced □ Widow/Widower

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: ___________________________
Name(s)/Age(s) of children of this marriage/relationship: _________________________
____

Name of Spouse/Partner: ____

Date of marriage/committed relationship: _________ Termination date: ____________
Reason: □ Death □ Divorce □ Other: ___________________________
Name(s)/Age(s) 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 specific 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 any special difficulties or problems in school? ◻ Yes ◻ No
If yes, please explain: ____
____

Did you have other satisfactions or achievements in school? ◻ Yes ◻ No
If yes, please explain: ____
____

Occupational History

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

Employer	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 1st Use	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 use 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 me to understand you as a person?

____

____

____

____

____

____