

Problem Information

Patient Name: _____

Briefly describe your chief concern:

Briefly describe the history and development of your concern from onset to present: _____

Describe your efforts to resolve your concern: _____

Current Stressors (describe HOW the following areas are stressful):

Marriage/Home _____

Children/Parents _____

Work/School _____

Financial _____

Social _____

Spiritual _____

Sexual _____

Other _____

Rate how strongly you want to change your present problem on the scale below:

(Don't want to change) 1 2 3 4 5 6 7 8 9 10 (Desperately want to change)

Identify any specific concerns or anxieties you have about counseling: _____

What are your goals for counseling (be specific) _____

Previous counseling? Y N When _____ By Whom _____

How helpful was previous counseling? _____

PERSONAL HISTORY

Describe any hobbies or interests you have _____

What club or organizational meetings do you attend? _____

What is your religious affiliation/Do you attend church? _____

Have you had any difficulties with the law ____ If so, explain: _____

MILITARY HISTORY

If you are a veteran, list your rank and duties _____

Describe any demotions, court martials, etc: _____

Where were you stationed and when _____

Were you hospitalized while in the service _____ How long _____

Did you receive compensation for a service disability _____

What kind of discharge did you receive _____

Describe your military experience _____

JOB HISTORY

Are you presently employed? _____

How long have you been employed there? _____

Do you enjoy your present position? _____ Why/Why not? _____

List any previous employment, how long employed, and why you left each position _____

If you could have any job you wanted, what would you choose? _____

FAMILY HISTORY

If you were not brought up by your parents, who raised you? _____

Between what years? _____ Who took primary care of you as an infant? _____

How were you disciplined as a child and by whom? _____

Give your impression of the home atmosphere in which you grew up, including how compatible you and everyone else were _____

Which siblings were you closest to growing up? _____

Which gave you the most trouble and why? _____

As you were growing up, how was love expressed in your home? _____

How was anger expressed? _____

Were you or your siblings ever physically and/or sexually abused, assaulted, or neglected? _____

	Name	Age	Education	Occupation	Location	State of Health
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Father	_____	_____	_____	_____	_____	_____
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Mother	_____	_____	_____	_____	_____	_____
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Brother	_____	_____	_____	_____	_____	_____
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Brother	_____	_____	_____	_____	_____	_____
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Sister	_____	_____	_____	_____	_____	_____
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Sister	_____	_____	_____	_____	_____	_____
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If either father or mother is deceased, when and at what age did death occur? _____
_____ Cause of death? _____

If a sibling is deceased, when and at what age did death occur? _____
_____ Cause of death? _____

Do any of your siblings have any illnesses or physical challenges? _____ Please list _____

Describe your father's personality, attitude, and relationship to you, past and present _____

Describe your mother's _____

Parents' marital status _____ Briefly describe your parent's marriage _____

How did they handle conflict in their relationship? _____

If divorced, when did it occur and what was your reaction to it? _____

If one or both parents remarried, when did they, and what was your reaction? _____

List step mother and/or father's name, age, occupation, education, and health _____

Describe their personality, attitude, and relationship to you, past and present _____

CHILDHOOD HISTORY

Describe your earliest memory _____

Describe playing before you started school _____

Describe yourself as a child (quiet, active, shy...) _____

Did you change while growing up? _____ How and When? _____

As a child, what things would make you angry? _____

How did you express your anger? _____

How did you seek attention/affection? _____

How easy was it for you to make friends in school? _____

Later on, as you grew up, how easy was it? _____

What people did you feel close to in your childhood? _____

DATING AND MARRIAGE

How old were you when you began dating and how often did you date as a teenager? _____

What was your dating experience like? _____

What sexual education did you receive? When and from whom? _____

Please describe your first encounter _____

Are you: Married _____ Divorced _____ Single _____ Widowed _____

How long have you been married to your present spouse? _____ If married previously, how many times have you been married? _____ How long each time? _____

How and why did you separate? _____

Describe the strengths of your marital relationships _____

Describe the relationship with your in-laws _____

Does your spouse have an illness or physical challenge and if so, what kind _____

Who handles the money? _____ Is there ever any conflict about this arrangement? If so, explain _____

List below any children by your present marriage (Name/Age/Sex) _____

List below any children by your previous marriage/your spouses previous marriage _____

Do any of your children have emotional, physical, or behavioral challenges? _____

Do you have any children who are not living _____ If so, list sex, age at time of death, year, and cause of death _____

Which child seems easiest to get along with and why? _____

Which child is most difficult and why? _____

Who disciplines the children and how? _____

SCHOOL HISTORY

What grade school/s did you attend? _____

Where _____ When _____

What high schools did you attend? _____

Where _____ When _____

What other schools did you attend? _____

Where _____ When _____

What two subject did you enjoy the most? _____

Whate two subjects did you enjoy the least? _____

What grades did you fail, if any? _____

What kind of student were you: Above Average _____ Average _____ Below Average _____

When did you leave school? _____ Why? _____

How old were you when you left school? _____

List the highest grade you completed or degrees _____

Describe your overall experience in school _____

SYMPTOMS CHECKLIST

Please check symptoms that you have experienced in the past six months.

PATIENT NAME _____ DATE _____

ACTIVITY	NONE	MILD	MODERATE	SEVERE
Decrease in energy or fatigue	0	0	0	0
Hyperactivity	0	0	0	0
Impulsivity	0	0	0	0
Increased social, occup, or sexual activity	0	0	0	0
Psychomotor agitation	0	0	0	0
Psychomotor retardation	0	0	0	0
Restlessness	0	0	0	0

BEHAVIOR	NONE	MILD	MODERATE	SEVERE
Academic or work inhibition	0	0	0	0
Aggression or rage	0	0	0	0
Antisocial	0	0	0	0
Compulsions	0	0	0	0
Deceitfulness or theft	0	0	0	0
Destructive	0	0	0	0
Disorganized	0	0	0	0
Oppositional/defiant	0	0	0	0
Reckless	0	0	0	0
Self-injurious	0	0	0	0
Social withdrawal	0	0	0	0
Violation of rules or rights of others	0	0	0	0

ANXIETY / PHOBIA	NONE	MILD	MODERATE	SEVERE
Anxiety	0	0	0	0
Fear of separation	0	0	0	0
Jitteriness	0	0	0	0
Panic attacks	0	0	0	0
Phobic responses	0	0	0	0
Somatization	0	0	0	0
Worrying	0	0	0	0

MOOD / AFFECT DISTURBANCE	NONE	MILD	MODERATE	SEVERE
Anger	0	0	0	0
Apathy	0	0	0	0
Blunted or flat affect	0	0	0	0
Depressed Mood	0	0	0	0
Elevated or expansive mood	0	0	0	0
Excessive or inappropriate guilt	0	0	0	0
Excitability	0	0	0	0
Feeling worthless	0	0	0	0
Grandiosity	0	0	0	0
Helplessness	0	0	0	0
Hopelessness	0	0	0	0
Irritability	0	0	0	0
Hostility	0	0	0	0

MOOD / AFFECT DISTURBANCE (con't)	NONE	MILD	MODERATE	SEVERE
Loss of interest or pleasure	0	0	0	0
Low self-esteem	0	0	0	0
Marked mood shifts	0	0	0	0
Tearfulness	0	0	0	0

SLEEP DISTURBANCE	NONE	MILD	MODERATE	SEVERE
Early morning awakening	0	0	0	0
Hypersomnia	0	0	0	0
Insomnia	0	0	0	0

COGNITION/MEMORY/ATTENTION	NONE	MILD	MODERATE	SEVERE
Aphasia	0	0	0	0
Diminished ability to think	0	0	0	0
Distractibility	0	0	0	0
Impaired abstract thinking	0	0	0	0
Impaired judgment	0	0	0	0
Indecisiveness	0	0	0	0
Memory impairment	0	0	0	0
Poor attention or concentration	0	0	0	0

FORM/AMOUNT OF THOUGHT/SPEECH	NONE	MILD	MODERATE	SEVERE
Circumstantiality	0	0	0	0
Flight of ideas	0	0	0	0
Incoherence or loosening of associations	0	0	0	0
More talkative than usual	0	0	0	0
Pressured speech	0	0	0	0
Racing thoughts	0	0	0	0
Slurred speech	0	0	0	0

PERCEPTUAL/THOUGHT DISTURBANCE	NONE	MILD	MODERATE	SEVERE
Delusions	0	0	0	0
Depersonalization	0	0	0	0
Grandiosity	0	0	0	0
Hallucination	0	0	0	0
Obsessions	0	0	0	0
Paranoid ideation	0	0	0	0
Recurring recollection of distressing events	0	0	0	0
Suicidal ideation	0	0	0	0

PHYSICAL SIGNS & SYMPTOMS	NONE	MILD	MODERATE	SEVERE
Autonomic	0	0	0	0
Cardiovascular	0	0	0	0
Gastrointestinal	0	0	0	0
Neurologic	0	0	0	0
Pain	0	0	0	0

EATING DISTURBANCE	NONE	MILD	MODERATE	SEVERE
Binge eating	0	0	0	0
Decreased appetite	0	0	0	0
Increased appetite	0	0	0	0
Inability to maintain normal body weight	0	0	0	0
Self induced vomiting	0	0	0	0

SUBSTANCE USE	NONE	MILD	MODERATE	SEVERE
Continued use in spite of knowledge of effects	0	0	0	0
Disrupts daily functioning (social life)	0	0	0	0
Inability to decrease use	0	0	0	0
Persistent desire for substance	0	0	0	0
Tolerance	0	0	0	0
Withdrawal	0	0	0	0
Excessive time to obtain, use or recover from effects	0	0	0	0
Drug(s) of choice: _____				

OTHER SYMPTOMS:	NONE	MILD	MODERATE	SEVERE
_____	0	0	0	0
_____	0	0	0	0
_____	0	0	0	0
_____	0	0	0	0
_____	0	0	0	0
_____	0	0	0	0
_____	0	0	0	0
_____	0	0	0	0