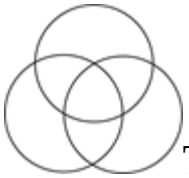


Trilogy Counseling Services

Family History Form

Client Name: _____Date: _____

Psychological History

1. **What problem(s) caused you to come for treatment?**

_____

_____

_____

   a. **When did the problem begin?_____**

   b. **Has the problem been constant since its beginning? Yes No**

   c. **What is the worst symptom you have had?_____**

   d. **Is the problem ever absent? Yes No**

   e. **If so, when?_____**

   f. **Who made the decision to come to therapy? _____**

2. **Have there been any recent illnesses or deaths among your family or close friends?**

   Yes No

3. **Have there been any recent major losses among your family or close friends? Yes No**

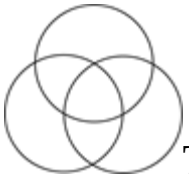
4. **Have there been any recent crises or major changes in your life? Yes No**

5. **Have you ever experienced any emotional, physical or sexual abuse? Yes No**

6. **Have you ever intentionally hurt yourself or made a suicide abuse? Yes No**

7. **Have you ever taken medication for anxiety, depression, sleep or other emotional conditions?**

   Yes No



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8. Have you ever been in counseling before? **Yes No**

a. **If so, for what issues?**_____

b. **When and where did you receive counseling?**_____

9. Have you had any hospitalizations for emotional problems?

Yes No

10. Please name any people or organizations that you believe provide help and support for you.

_____

_____

_____

Medical History

1. List any current medical conditions or disabilities.

_____

2. Are you taking any medications? **Yes No**

a. **List current medications and dose on medication sheet.**

3. List any past medical conditions (include any surgeries):

_____

4. Name of your primary care physician.

Name:_____

Phone:_____

Address:_____

5. Have you had a medical exam within the past year? **Yes No**

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Symptom Checklist

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4= Extremely

1. Feeling depressed, sad, blue, down, unhappy most of the time 0 1 2 3 4

2. Feeling easily annoyed or irritated 0 1 2 3 4

3. Feeling no interest in things or avoiding enjoyable activities, family, or friends 0 1 2 3 4

4. Feeling tired all the time even with adequate sleep 0 1 2 3 4

5. Trouble concentrating; can't stay focused on activities 0 1 2 3 4

6. Feeling lonely even when you are with people 0 1 2 3 4

7. Feeling hopeless about the future 0 1 2 3 4

8. Significant increase or decrease in appetite or weight 0 1 2 3 4

9. Sleeping problems: Can't fall asleep, restless sleep, sleeping too much 0 1 2 3 4

10.Thoughts of suicide: thinking "I wish I were dead," "Life isn't worth living anymore"

0 1 2 3 4

11. Suicide attempt: Intent or action to hurt or kill self with pills, weapons, cuts, etc.

0 1 2 3 4

12. Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money 0 1 2 3 4

13. Doing things without thinking and often getting yourself into a jam 0 1 2 3 4

14. Feeling so restless you could not sit still 0 1 2 3 4

15. Feeling anxious: Worrying excessively or worry about many things 0 1 2 3 4

16. Feeling tense or keyed up 0 1 2 3 4

17. Spells of terror or panic 0 1 2 3 4

18. Fearful feelings of being humiliated in social situations 0 1 2 3 4

19. Feeling uneasy in crowds or in open spaces 0 1 2 3 4

20. Feeling afraid to travel on buses, subways, trains, or planes 0 1 2 3 4

21. Feeling inferior to others 0 1 2 3 4

22. Having to avoid certain things, places or activities because they frighten you 0 1 2 3 4

23. Sudden re-experiencing of feelings, thought, images of a traumatic event 0 1 2 3 4

24. Temper outbursts that you could not control 0 1 2 3 4

25. Feeling "nothing" or numb, as if blocked as in taking a painkiller 0 1 2 3 4

26. Recurrent thoughts, impulses, or images that are intrusive and troubling 0 1 2 3 4

27. Excessive repeating of an activity that you could not resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc.) 0 1 2 3 4

28. Feeling that you are watched or talked about by others 0 1 2 3 4

29. Seeing or hearing things outside yourself that others tell you are not really there 0 1 2 3 4

30. The idea that someone else can control your thoughts 0 1 2 3 4

31. Feeling that most people cannot be trusted 0 1 2 3 4

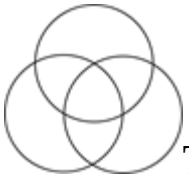
32. Persistent fears about health problems despite doctors finding nothing wrong 0 1 2 3 4

33. Episodes of binge eating, purging/vomiting, or restrictive eating 0 1 2 3 4

34. Feeling others are to blame for most of your troubles 0 1 2 3 4

35. Having urges to break or smash things or injure someone 0 1 2 3 4

36. Other:_____ 0 1 2 3 4



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Drug and Alcohol Use

0 = never; 1 = less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = past use

Caffeine –

Nicotine –

Beer/Wine/Liquor –

LSD –

Marijuana –

Inhalants –

Sedatives –

Amphetamines –

Cocaine/Crack –

Other (specify) –

B. Are you concerned about drug or alcohol abuse?

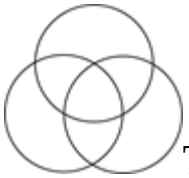
C. Is someone who cares about you concerned about the use of drugs or alcohol?

D. Do you ever feel guilty about the use of drugs or alcohol?

E. Are you concerned about the alcohol or drug use of someone in your family?

F. Did you grow up in a home in which a parent or guardian abused drugs or alcohol?

G. Has anyone in your family been in treatment for drugs or alcohol? Please list below.



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Financial/Legal History

A. Do you have serious financial concerns? Yes No

B. Have you ever been arrested? Yes No

C. Have you ever been involved with Protective Services: Yes No

School, Military and Work History

A. Are you currently enrolled in school? Yes No

B. What is your highest grade completed? _____

C. If you are in school, what field are you studying? _____

D. Have you served in the military: Yes No

a. What branch?

E. Are you currently employed? Yes No

a. If yes, what is your occupation? _____

b. What is the length of time at your current job? _____