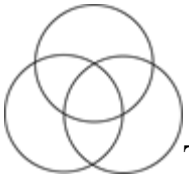

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**Family History Form**

**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**

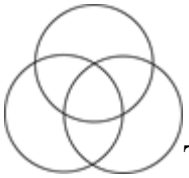
**4. Have there been any recent crises or major changes in your life? Yes No**

**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):**

_____

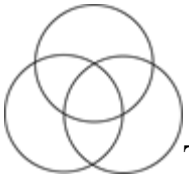
**4. Name of your primary care physician.**

**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**

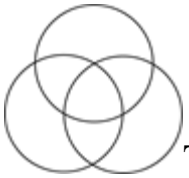
**13. Doing things without thinking and often getting yourself into a jam 0 1 2 3 4**

**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**



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**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**

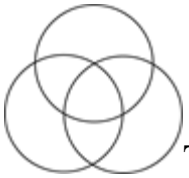
**32. Persistent fears about health problems despite doctors finding nothing wrong 0 1 2 3 4**

**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?**

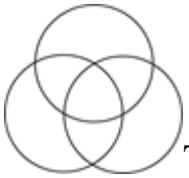
**C. Is someone who cares about you concerned about the use of drugs or alcohol?**

**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? _____**