PRETREATMENT DATA FORM - *ADULT VERSION*

Center for Integrative Psychotherapy
Allentown, Pennsylvania www.cip-cbt.com

This questionnaire seeks to obtain information about you, your problems and background in order to better understand you and to design an effective treatment plan. Any questions about the information you are providing can be discussed during the subsequent therapy session. The information provided by you is strictly confidential and nobody will be permitted access to it without your consent. Feel free to leave blank any question or part of a question that you do not wish to answer or that you think is irrelevant to your problem(s).

Date:_____200_____

DEMOGRAPHICS AND GENERAL INFORMATION

Name:_____ Age:____ Gender: M____ F_____

Day phone:_____ Eve/Home phone:_____

Date of Birth:_____ Place of Birth:_____

Religion (Optional):_____ Referred by:_____

Family Physician:_____ If applicable, Psychiatrist:_____

Relationship Status: Single ____ Engaged ____ Married ____ Separated ____
Divorced ____ Widowed ____ Cohabiting ____

With whom do you reside: Self ____ Parents ____ Spouse/Partner _____
Roommate ____ Friends___ Your children ___ Other (Specify:_____
_____)

In case of emergency, notify:_____ Phone:_____

Are you presently seeing another psychotherapist? Yes___ No___ if Yes, therapist's name_____ Therapist's phone: _____

PRESENTING PROBLEM(S)

1. PROBLEM LIST:

Please list the problems that you would like help with in psychological therapy, and rate

the severity of each one according to the scale below (please start with the most important one)*:*

1	2	3	4
Slightly upsetting	Moderate	Overwhelming	Incapacitating

RATING

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

2. MAIN PRESENTING PROBLEM:
Please describe the main problem that brings you to therapy?

_____

_____

_____

2.1 How often does your problem occur?
Every day___ Several times a week___ Once a week___ Every two weeks___ Every three weeks___ Once a Month____ Less than once a month___

2.2. What causes your main problem? What explanation do you give yourself for problem?

_____

_____

2.3. **Conditions that affect your problem.**
2.3.1. **Worse.** Under what conditions or situations does your problem usually get worse?_____

_____

2.3.2. **Better.** Under what situations does your problem usually improve or situations in which the problem does not occur? _____

_____

_____

3. HISTORY OF YOUR MAIN PROBLEM

3.1. **Current main problem onset.** When would you say the main problem or symptoms began? Approximate date _____ or how long ago?_____

Since the onset of the current problem problem/symptoms, they have gotten:
Better___ Worse____ Same____

3.2. **Previous episodes of the present of main problem/symptoms**.
3.2.1. Have you experienced similar episodes of the problem/symptoms in the past?
Yes____ No____ If Yes,

3.2.1. How many episode of the same problem have you had? _____

3.2.3. When would you say these symptoms/problems began for the first time? How old were you? _____ years old. How long ago?_____

3.2.4. What was happening in your life then? _____

_____

3.2.5. How long did the first episode last (hours, days, months, years)? _____

3.2.6. Since the first episode, has your problem gotten: Worse__ Same___ Better___

3.3. **Did you ever overcome the problem?** Yes___ No___ If YES,
3.3.1 How did you overcome the problem? Please circle one or more options:

A- I made it go away
B- It disappeared by itself
C- I received psychiatric medication treatment
D- I received psychological treatment
E- I received other type of help:_____

3.4. **Coping.** In order to deal with problems, people often engage in different kinds of coping behaviors. How have you tried to cope with your main problem/symptoms?. Also, describe the results you have derived from using your coping techniques.

_____

_____

3.5. **Social support**. Do you have people (e.g., family, friends, spouse) with whom you

can count on to help you deal with the current problem(s)? Yes___ No___ If Yes, Who?

_____

3.6. **Importance.** How important is the current problem in your life?. Choose any of the following categories?

Little____ Moderate____ Very____ Extremely____

3.7. **Consequences**. Please rate the level of impairment that your *current main problem or symptoms* are causing in each area of your life **(0= None; 1= mild; 2= moderate; 3= severe; 4= disabling; NA= non applicable)**. Also, explain how does the problem affect your life in the following areas:

Work/Vocation/Education: **0 1 2 3 4 NA** Explain:_____
_____

Relationship with your immediate family: **0 1 2 3 4 NA** Explain: _____
_____

Dating, couple relationship: **0 1 2 3 4 NA** Explain:_____
_____

Social life: **0 1 2 3 4 NA** Explain:_____
_____

Physical/Health: **0 1 2 3 4 NA** Explain:_____
_____

Finances: **0 1 2 3 4 NA** Explain:_____

_____

Sexual life: **0 1 2 3 4 NA** Explain:_____
_____

Spiritual life: **0 1 2 3 4 NA** Explain:_____
_____

Leisure, recreational, humor: **0 1 2 3 4 NA** Explain:_____
_____

4. MENTAL HEALTH TREATMENT HISTORY

4.1. Psychological Treatment History

Have you seen a psychotherapist (psychologist, counselor, social worker) for your **current** problem(s)? Yes___ No___ If YES, please list below

Therapist's name_____ When (dates) _____
Where (facility, city)_____For how long? _____

Therapist's name_____ When (dates) _____
Where (facility, city)_____For how long? _____

Therapist's name_____ When (dates) _____
Where (facility, city)_____For how long? _____

4.2. Did you have other types of psychological/psychiatric problems in the past?. If YES, please, describe the nature of such problems and how did you overcome them.

_____
_____
_____
_____
_____
_____
_____
_____

4.2. Psychiatric Treatment History

4.2.1. Have you seen a psychiatrist for your **current** problem(s)? Yes___ No___If YES, Whom?_____ When was your last visit_____ Where (facility, city)_____ When is your next visit?_____

4.2.2. If you are **currently** taking psychiatric medications as part of your treatment for the present problems/symptoms, please indicate:

Prescribing physician's name:_____ Phone_____

Name of med.	Dose (mg/day)	Date 1st used	Date last used	Response Poor Fair Good

Have you noticed any side effects from any of the medications?

No____ Yes____ Which_____

4.2.3. Psychiatric medications you are no longer using, but you used in the past **to treat your current problem**(s)

Name of med.	Dose (mg/day)	Date 1st used	Date last used	Response Poor Fair Good

4.2.4. Have you **ever** been on **any** psychiatric medications in the past for other psychological or psychiatric problems? If Yes_____

Name of med.	Dose (mg/day)	Purpose	Prescribing MD	Last used

4.2.5. Have you ever been hospitalized for a psychological problems (including alcohol or substance abuse)? Yes____ No____ If YES, please indicate:

Name of the hospital_____ City_____ State_____
When_____ Total days____ Reason for hospitalization _____
_____

Name of the hospital_____ City_____ State_____
When_____ Total days____ Reason for hospitalization_____
_____

Name of the hospital_____ City_____ State_____
When_____ Total days____ Reason for hospitalization_____
_____

Name of the hospital_____ City_____ State_____
When_____ Total days____ Reason for hospitalization_____
_____

5. CURRENT DISTRESSING EXPERIENCES

Below is a list of problem and complaints that people sometime have. Please indicate the approximate frequency with which each of the following experiences have been a problem for you **during the past month including today**. Use the following scale:

0 Never/Non applicable
1 very seldom
2 not frequently
3 more often than not
4 almost everyday
5 everyday

Mood Problems

1. Feeling hopeless	0 1 2 3 4 5
2. Unjustified fears	0 1 2 3 4 5
3. Feeling lonely	0 1 2 3 4 5
4. Feeling irritable	0 1 2 3 4 5
5. Empty/Void	0 1 2 3 4 5
6. Sad/blue	0 1 2 3 4 5
7. Pessimistic	0 1 2 3 4 5
8. Inadequate	0 1 2 3 4 5
9. Depressed	0 1 2 3 4 5
10. Angry at others	0 1 2 3 4 5
11. Angry at myself	0 1 2 3 4 5
12. Overwhelmed	0 1 2 3 4 5
13. Pressured	0 1 2 3 4 5
14. Inferior to others	0 1 2 3 4 5
15. Worthless	0 1 2 3 4 5
16. Superior to others	0 1 2 3 4 5
17. Difficulty experiencing joy	0 1 2 3 4 5
18. Fearful of losing control	0 1 2 3 4 5
19. Guilty	0 1 2 3 4 5
20. Bored	0 1 2 3 4 5
21. Envious	0 1 2 3 4 5
22. Jealous	0 1 2 3 4 5
23. Agitated	0 1 2 3 4 5
24. Panicky	0 1 2 3 4 5
25. Feeling trapped	0 1 2 3 4 5
26. Mood swings	0 1 2 3 4 5
27. Anxious	0 1 2 3 4 5
28. Embarrassed	0 1 2 3 4 5
29. Spiteful	0 1 2 3 4 5
30. Bitter	0 1 2 3 4 5
31. Helpless	0 1 2 3 4 5

Cognitive Problems

0 Never
1 very seldom
2 not frequently
3 more often than not
4 almost everyday
5 everyday

1. Blaming myself	0 1 2 3 4 5
2. Blaming others	0 1 2 3 4 5
3. Difficulty concentrating	0 1 2 3 4 5
4. Catastrophic thoughts	0 1 2 3 4 5
5. Catastrophic images	0 1 2 3 4 5
6. Worry thoughts	0 1 2 3 4 5
7. Forgetful	0 1 2 3 4 5
8. Nightmares	0 1 2 3 4 5
9. Thoughts difficult to control	0 1 2 3 4 5
10. Self-critical thoughts	0 1 2 3 4 5
11. Self-conscious	0 1 2 3 4 5
12. Critical of others	0 1 2 3 4 5
13. Concern with other's opinion of me	0 1 2 3 4 5
14. Thoughts of hurting myself	0 1 2 3 4 5
15. Thoughts of killing myself	0 1 2 3 4 5
16. Thoughts of hurting others	0 1 2 3 4 5
17. Thoughts of killing others	0 1 2 3 4 5
18. Disoriented	0 1 2 3 4 5
19. Poor sense of time	0 1 2 3 4 5
20. Confused	0 1 2 3 4 5
21. Daydreaming	0 1 2 3 4 5
22. Racing thoughts	0 1 2 3 4 5
23. Unwanted thoughts	0 1 2 3 4 5
24. Disappointed in myself	0 1 2 3 4 5
25. Disappointed with others	0 1 2 3 4 5
26. Worried that someone can control my thoughts	0 1 2 3 4 5
27. Hearing voices or seeing things other people do not hear or see	0 1 2 3 4 5
28. Indecisiveness	0 1 2 3 4 5

Behavioral Problems

1. Smoking too much	0 1 2 3 4 5
2 Abuse of alcohol	0 1 2 3 4 5
3. Abuse of caffeine	0 1 2 3 4 5
4. Abuse of other drugs	0 1 2 3 4 5
5. Overeating	0 1 2 3 4 5

0 Never
1 very seldom
2 not frequently
3 more often than not
4 almost everyday
5 everyday

6. Eating too little	0 1 2 3 4 5
7. Too passive	0 1 2 3 4 5
8. Too restless	0 1 2 3 4 5
9. Difficulty relaxing	0 1 2 3 4 5
10. Tics	0 1 2 3 4 5
11. Aggressive behaviors	0 1 2 3 4 5
12. Inappropriate sexual behaviors	0 1 2 3 4 5
13. Crying	0 1 2 3 4 5
14. Nail biting	0 1 2 3 4 5
15. Impulsive reactions	0 1 2 3 4 5
16. Stuttering	0 1 2 3 4 5
17. Gambling	0 1 2 3 4 5
18. Pulling my hair	0 1 2 3 4 5
19. Unable to control certain repetitive behaviors	0 1 2 3 4 5
20. Taking unnecessary risks	0 1 2 3 4 5
21. Argue a lot with others	0 1 2 3 4 5
22. Deliberately annoy people	0 1 2 3 4 5
23. Sloppiness	0 1 2 3 4 5

Somatic/Bodily Changes

1. Nausea, vomiting	0 1 2 3 4 5
2 Headaches	0 1 2 3 4 5
3. Fatigue/Lack of energy	0 1 2 3 4 5
4. Difficulty breathing	0 1 2 3 4 5
5. Diarrhea	0 1 2 3 4 5
6. Constipation	0 1 2 3 4 5
7. Sleeping too much	0 1 2 3 4 5
8. Insomnia	0 1 2 3 4 5
8. Numbness	0 1 2 3 4 5
9. Palpitations	0 1 2 3 4 5
10. Heart racing	0 1 2 3 4 5
11. Chest pressure	0 1 2 3 4 5
12. Hot/cold flashes	0 1 2 3 4 5
13. Dizziness/light headiness	0 1 2 3 4 5
14. Blushing	0 1 2 3 4 5
15. Bowel disturbances	0 1 2 3 4 5
16. Tremors	0 1 2 3 4 5

0 Never
1 very seldom
2 not frequently
3 more often than not
4 almost everyday
5 everyday

17. Chronic pain	0 1 2 3 4 5
18. Dry mouth	0 1 2 3 4 5
19. Skin problems	0 1 2 3 4 5
20. Excessive sweating	0 1 2 3 4 5
21. Fainting spells	0 1 2 3 4 5
22. Shakiness	0 1 2 3 4 5
23. Backaches	0 1 2 3 4 5
24. Chest pain	0 1 2 3 4 5
25. Seizures	0 1 2 3 4 5

Interpersonal Problems

01. Marital/couples conflicts	0 1 2 3 4 5
02. Conflicts with others	0 1 2 3 4 5
03. No friends	0 1 2 3 4 5
04. Submissive	0 1 2 3 4 5
05. Shy	0 1 2 3 4 5
06. Attempting to control	0 1 2 3 4 5
07. Socially withdrawn/avoidant	0 1 2 3 4 5
08. No interested in socialize	0 1 2 3 4 5

6. RECENT STRESSFUL LIFE EVENTS
(Brugha, T.S. & Cragg, D., 1990; Modified by Salas, J.A., 2003)

Have any of the following life events happened to you during ***the last twelve months***?. Please, indicate approximately how many months ago each of the relevant event happened or began. Also, indicate the impact that such events had in your life; use the following scale: from **0** = "**Not at all**" to **5** = "**Extremely significant/affected me a great deal**"

You suffered a serious illness, injury or an assault
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

A close relative, romantic partner/spouse died or suffered a serious illness, injury or an assault
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

A close friend died or suffered a serious illness, injury or an assault
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

You had a separation due to marital difficulties/a steady romantic relationship was broken off or is about to be terminated
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

You remarried.
No_____ Yes____ Months____ Impact 1 2 3 4 5

You changed your residency
No_____ Yes____ Months____ Impact 1 2 3 4 5

You became unemployed or you were seeking work unsuccessfully for more than one month
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

You changed jobs/changed school
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

You had a promotion in your job
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

You had a major financial crisis
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

Something valuable to you was lost or stolen
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

You had problems with the police or a court appearance
No_____ Yes_____ Months_____ Impact 1 2 3 4 5

Other significant stressor:_____
Months_____ Impact 1 2 3 4 5

7. SUICIDE HISTORY

Have you ever seriously considered taking your own life?

Yes____ No____ If YES, please explain/when_____
_____

Have you ever attempted to take your own life?

Yes____ No____ If YES, please explain: (a) How many times____ When
_____

What was happening in your life at that time?_____

Has anybody in your family attempted suicide? Yes___ No___ If YES,

who_____ When_____

Has anybody in your family committed suicide? Yes___ No___ If YES,

who_____ When_____

8. DRUG AND ALCOHOL HISTORY

If you have a history of street drugs and/or alcohol abuse, please describe your pattern of use (past and present), and the consequences of your drug/alcohol problem:
_____
_____

Do you *currently* use street drugs? Yes____ No____ If so, please explain:
_____

Have your family or friends expressed concern about your use of alcohol or drugs in the past year? No_____ Yes_____ If YES, please explain:_____
_____

Have you ever been arrested for alcohol/drug related charges? (e.g., D.U.I., public intoxication, etc.) No___ Yes___ If YES, please explain:_____
_____

Has your driver license ever been suspended? Yes___ No___ If so, please explain why?_____
_____

9. HEALTH/MEDICAL HISTORY

In general, would you say that health is (check one):

Excellent___ Very good___ Good___ Fair____ Poor____

Do you suffer from any general medical condition that can be associated to your psychological problems? Yes____ No____ If "Yes", please explain:_____
_____

When was your last medical examination? _____ Please, indicate the name _____ and specialty _____ of the physician or health practitioner you visited the last time.

Do you have any health condition/illness that represent a threat to your health and interferes with your life (e.g. Diabetes, hypertension, asthma, arthritis)?

No____ Yes____ If Yes, please describe:_____
_____

Please indicate any medication that you are you currently taking for that condition/illness? Indicate name, dose and frequency a day. Also, name the prescribing physician

Physician's name:_____

Name of med.	Dose (mg)	Frequency	Duration	Purpose

Have you noticed any side effects from any of the medications?

No____ Yes____ If Yes, please explain: _____

Do you exercise on a regular basis? Yes___ No___ If Yes, what kind of exercise do you do? _____ How many times a week? _____ How long each time? _____

10. CHILDHOOD AND FAMILY HISTORY

10.1. YOUR FATHER

Name of the person you consider your father_____ Age:_____ Is this man your: Biological___ Adoptive___ Stepfather___ Grandfather___ Other:_____ Father's occupation:_____ Your father's health: Poor____ Moderate____ Good____ Very Good____
If deceased, give his age at time of death:_____ Cause of death:_____
How old were you at the time?_____ What was the last grade of school he completed?_____ Please, provide a brief description of your relationship with your father during childhood: _____
_____
_____

As a child:

Were you able to confide in your father?
Very much____ Somewhat____ Little____ Not at all____

Did you feel loved and liked by your father?
Very much____ Somewhat____ Little____ Not at all____

Did you love your father?
Very much____ Somewhat____ Little____ Not at all____

Did you like your father?
Very much____ Somewhat____ Little____ Not at all____

Did you feel understood and respected by your father?
Very much____ Somewhat____ Little____ Not at all____

Did you feel physically protected by your father?
Excessively____ Sufficiently____ Not enough____ Not at all____

When you were emotionally upset, Did you feel protected/supported by your father?
Excessively____ Sufficiently____ Not enough____ Not at all____

How much time did he spend with you when you were a child?
Excessively____ Sufficiently____ Not enough____ Not at all____

Did he encourage your exploration of the outside world?
Excessively____ Sufficiently____ Not enough____ Not at all____

How did he discipline you when you misbehaved? _____

How did he reward you?_____

Did your father have any problems (e.g., alcoholism, depression, etc.) that may have affected your childhood development? Yes___ No____ If YES, please describe: _____
_____

What important messages about yourself -who you are- you learned from your relationship with your father growing up? _____
_____

What important messages about others you learned from your relationship with your father growing up? _____
_____

What important messages about the world/life you learned from your relationship with your father growing up? _____
_____

If applicable, mention any changes in your relationship with him now compared to when

you were child. What is your relationship with your father like for you currently?
_____
_____

If the above name person is not your biological father, please indicate his name, current age, occupation and your relationship (kinship) with him. _____
_____

10.2. YOUR MOTHER

Name of the person you consider your mother_____ Age:___ Is this woman your: Biological___ Adoptive___ Stepmother___ Grandmother___ Other:_____ mother's occupation:_____ Your mother's health: Poor____ Moderate____ Good____ Very Good____ If deceased, give her age at time of death:_____ Cause of death:_____ How old were you at the time?_____ What was the last grade of school she completed?_____
Please, provide a description of your relationship with your mother during childhood.
_____
_____
_____

As a child:

Were you able to confide in your mother?
Very much____ Somewhat____ Little____ Not at all____

Did you feel loved and liked by your mother?
Very much____ Somewhat____ Little____ Not at all____

Did you love your mother?
Very much____ Somewhat____ Little____ Not at all____

Did you like your mother?
Very much____ Somewhat____ Little____ Not at all____

Did you feel understood and respected by your mother?
Very much____ Somewhat____ Little____ Not at all____

Did you feel physically protected by your mother?
Excessively____ Sufficiently____ Not enough____ Not at all____

When you were emotionally upset, Did you feel protected/supported by your mother?
Excessively____ Sufficiently____ Not enough____ Not at all____

How much time did she spend with you when you were a child?
Excessively____ Sufficiently____ Not enough____ Not at all____

Did she encourage your exploration of the outside world?
Excessively____ Sufficiently____ Not enough____ Not at all____

How did she discipline you when you misbehaved?_____
_____

How did she reward you?_____
_____

Did your mother have any problems (e.g., alcoholism, depression, etc.) that may have affected your childhood development?

Yes___ No____ If YES, please describe:_____
_____

What important messages about yourself -who you are- you learned from your relationship with your mother growing up? _____
_____

What important messages about others you learned from your relationship with your mother growing up? _____
_____

What important messages about the world/life you learned from your relationship with your mother growing up? _____
_____

If applicable, mention any changes in your relationship with her now compared to when you were child. What is your relationship with your mother like for you currently?
_____
_____

If the above name person is not your biological mother, please indicate your biological mother's current age, occupation and your current relationship with her.
_____
_____

Were you ever separated from one or both of your parents for a period of time during your childhood? Yes____ No____ If, YES, please provide a description of the individuals you resided with?. Name(s), How many years (months) did you live with them?, How was their relationship with you?.
_____
_____

11. EXPRESSION OF EMOTIONS

As a child, how did your parents react to you when you felt or expressed the following emotions? Usually your feelings were:

Sadness
A) denied___ B) encouraged___ C) punished____ D) ignored____ E) Allowed___

Happiness/Excitement
A) denied___ B) encouraged___ C) punished____ D)ignored____ E) Allowed___

Anger
A) denied___ B) encouraged___ C) punished____ D) ignored____ E) Allowed___

Fear and insecurity
A) denied___ B) encouraged___ C) punished____ D) ignored____ E) Allowed___

Affection
A) denied___ B) encouraged___ C) punished____ D) ignored____ E) Allowed___

12. COPING WITH FAMILY DISTRESS

If you grew up feeling insecure and/or unimportant/neglected, how did you respond to your feelings of insecurity or worthlessness? Please, check one or more of the following options:

A) By becoming very dependent on your family _____
B) By becoming the perfect child and not creating additional trouble for my family_____
C) By becoming very independent of your family_____
D) By becoming angry and rebellious_____
E) Other_____

13. RELIGION & BELIEFS ABOUT LIFE

Within what religion were you brought up? _____

Was religion an important influence in your life? Yes___ No____

If YES, explain how:_____

What is your current religious affiliation?_____

Does religion play an important role in your life? Use the following scale to answer: 0 to 9: ____

0 = Not at all
3 = Little
5 = moderate
7 = Important
9 = Very important

Using the same scale from 0 to 9 indicate how much of a concern are each of the followings areas:

1. Needing a philosophy of life .....___
2. Losing earlier religious beliefs .....___
3. Confused in your religious beliefs .....___
4. Feeling life is not worthwhile .....___
5. Not getting satisfactory answers from any religion ___
6. Confused in terms what I want out of life .....___
7. Other_____ .....___

14. SIBLINGS

Please, state the full names of your siblings, as well as, their ages and occupations (From the oldest to the youngest, include yourself on the list; also indicate if they have different mothers or fathers:

1. _____ Age:_____ Occupation:_____
2. _____ Age:_____ Occupation:_____
3. _____ Age:_____ Occupation:_____
4. _____ Age:_____ Occupation:_____
5. _____ Age:_____ Occupation:_____
7. _____ Age:_____ Occupation:_____
8. _____ Age:_____ Occupation:_____

Please, describe your past relationship with your brothers/sisters:
_____
_____

How is your current relationship with them? _____
_____
_____

Did your parents treat you differently than your siblings? Yes___ No___ If YES, (A) please explain in which way_____

(B) Why do you think they treated you differently? _____
_____

How many times did your family move during your childhood and adolescent years?_____ Were those moves a problem for you? Yes____ NO____ Non-Applicable__

15. FAMILY PSYCHIATRIC HISTORY

Did your parents, grandparents, or other close relatives (e.g., uncle, aunt, brother, sister) suffered from:

	Father	Mother	Grandparents	Other relatives
Phobias	------	---------	----------	----------
Panic attacks	------	---------	----------	----------
Anxiety/Chronic worry	------	---------	----------	----------
OCD	------	---------	----------	----------
Depression	------	---------	----------	----------
Bipolar Disorder	------	---------	----------	----------
Alcohol abuse	------	---------	----------	----------
Drug abuse	------	---------	----------	----------
ADHD	------	---------	----------	----------
Eating disorder	------	---------	----------	----------
Social phobia	------	---------	----------	----------
Schizophrenia	------	---------	----------	----------
Agoraphobia	------	---------	----------	----------
Other import. problems	------	---------	----------	----------

Have any of your siblings been treated for any mental disorder? Whom?, What type of disorder? When? _____

16. SIGNIFICANT PAST EVENTS IN YOUR LIFE

Did anything *specially positive* happen to you as a child or adolescent? Yes____ No____ If yes, What happened?_____
_____

How old were you?_____ How did you feel?_____

Have you ever suffered *any abuse* (psychological, physical, sexual)? _____ Yes _____ No If your answer is Yes, What happened?, What kind of abuse? When?, How old were you?, How many times? Where?, Who else was involved? _____
_____
_____
_____
_____

Would you consider that experience as something traumatic? Yes___ No___ How do you believe that experience of abuse has affected you?. _____
_____
_____

Have you ever experience a traumatic event in your life? Yes___ No___. If Yes, What happened?_____
_____
_____

How old were you?_____ How did you feel?_____
_____

Are you still affected by such event(s) Yes____ No____ If yes, How_____
_____

17. RELATIONSHIP WITH YOUR ROMANTIC PARTNER/SPOUSE

Finding a suitable romantic partner:
Non applicable____ It's a problem____ It's not a problem____

If you have a partner, spouse, boyfriend/girlfriend, please describe this person:

What is his/her name?_____ Age_____, Occupation_____

How is his/her present relationship with you?_____

How long have you been in this relationship?_____

What do you like the most about your spouse/partner?_____
_____

What do you like the least about your spouse/partner?_____
_____

How is the relationship with your spouse, partner, girlfriend, boyfriend's family? _____
_____

Have you noticed a pattern of problems in the area of romantic relationships in your life? Yes____ No_____ If YES, please give detail: _____
_____
_____

If you have been divorced one or more times, please list the length of each marriage:

1. Length of first marriage _____
2. Length of second marriage _____
3. Length of third marriage _____
4. Length of fourth marriage _____

If you have been widowed one or more times, please list your spouses age at death and cause of death:

1. First spouse's age at death _____ cause of death_____
2. Second spouse's age at death ____ cause of death_____
3. Third spouse's age at death _____ cause of death_____

18. SEXUAL LIFE

Are there any problems in your sexual life? No _____ Yes _____ If YES, please, indicate what kind of problems (check as many as apply):

Lacking information about sex ___
Finding it difficult to control your sexual impulses ___
Losing/lost interest in sex ___
Losing/lost interest in sex with your romantic partner ___
Unwanted sexual thoughts/images or desires ___
Excessive worries about pregnancy ___
Bothered by sexual dreams ___
Sexually attracted to some of the same sex when you don't want to ___
Sexually unsatisfied ___
Sexually attracted to someone different from romantic partner ___
Experiencing performance problems (e.g., premature ejaculation, ED) ____
Having difficulty becoming sexually aroused ____
Having difficulty in reaching orgasm ____
Excessive masturbation ____
Worries about past or present masturbation ___
Finding intercourse painful ____
Finding intercourse impossible ____
Finding intercourse repulsive ____
Your partner has sexual problems ____
Your sexual desire is significantly less than your partner's ___
Your sexual desire is significantly more than your partner's ___
Guilty feelings about past sexual experiences ____
Other: _____

19. CHILDREN

Do you have difficulty in deciding whether to have children or not?
Non applicable____ It's a problem____ It's not a problem____

Do you have children? Yes_____ No _____ If the answer is Yes: Please, indicate their names and ages below (from the oldest to the youngest).

1. _____ Age:_____ Education:_____
2. _____ Age:_____ Education:_____
3. _____ Age:_____ Education:_____
4. _____ Age:_____ Education:_____

Do any of your children have special problems? Yes_____ No _____ If yes, please describe the nature of such problems:_____
_____
_____

Are you having problems with child-rearing? Non applicable____ Yes___ No____, If YES, please explain:_____
_____

12. SOCIAL RELATIONSHIPS HISTORY

Do you have trouble making friends? Yes_____ No_____ If YES, please explain the nature of your difficulties: _____
_____

Do you have trouble keeping friends? Yes_____ No_____ If YES, please explain the nature of your difficulties: _____
_____

Do you have trouble in your relationships with others? Yes____ No_____ If YES, please give detail_____
_____

At present, do you have good/close friends? Yes___ No__ If YES, name them:
1._____ 2._____
3._____ 4._____

How often do you see your friends?_____

Who is the person(s)you most like to spend time with?_____
_____

Who is the person(s) you want to be with when you are feeling upset or down?
_____

Who is the person(s) you can always count on? _____

Who is the person(s) you would want to tell first if you achieved something good?
_____

13. ACADEMIC HISTORY

Please, indicate the highest grade completed in school or highest degree earned:
Elementary___ H.S.____ Associates Degree___
Bachelors Degree___ Masters___ Doctorate___

Are currently a student? Yes___ No___ If YES, please indicate:

Full-time___ Part-time___ School_____ Program___

Please describe any school experience(s) that you consider significant in your life (which had/have an important impact). If there are none, proceed to the next question.
_____
_____
_____
_____

EMPLOYMENT HISTORY

What is your current employment status? You can circle more than one option:
a. Full time b. Part time c. Unemployed-looking for job

d. Unemployed-not looking for job f. Disabled g. Homemaker h. Retired

What is your current occupation?_____

On average, how many hours per week do you work?: _____ hours.

Any significant problems in this area? If Yes, briefly describe the type of problems you have experienced with work either at your current job or in the past:

At present: _____
_____

In the past:_____
_____

Please indicate which of the following are current problems for you by selecting the

number that best reflects your situation. Use the following scale:

0 Not at all
1 Minimal problem
2 Somewhat problematic
3 Moderate problem
4 Serious problem
5 Very serious problem

1. Working physically too hard..... 0 1 2 3 4 5
2. Working mentally too hard..... 0 1 2 3 4 5
3. Working too many hours..... 0 1 2 3 4 5
4. Not interested or challenged at work 0 1 2 3 4 5
5. Having problems with co-workers..... 0 1 2 3 4 5
6. Having problems with my supervisor..... 0 1 2 3 4 5
7. Not satisfied with my salary..... 0 1 2 3 4 5
8. Unable to handle the responsibilities of my job..... 0 1 2 3 4 5
9. Difficulty combing work and family life..... 0 1 2 3 4 5
10. Insecure future in my company/job..... 0 1 2 3 4 5

GENERAL SATISFACTION WITH YOUR LIFE

(Diener, E., Emmons, R.A., Larse, R.J. & Griffin, S. 1985)

Below are five statements with which you may agree or disagree. Using the following scale, indicate your degree of agreement with each statement by placing the appropriate number in the space to the right.

1 Strongly disagree 2. Disagree 3. Slightly disagree 4. Unsure
5. Slightly agree 6. Agree 7. Strongly agree

1. In most ways my life is close to my ideal. _____
2. The conditions in my life are excellent. _____
3. I am satisfied with my life. _____
4. So far I have achieved the important things I want in life. _____
5. If I could live my life over, I wouldn't change almost anything. _____

GENERAL LEVEL OF SATISFACTION AND FUNCTIONING

Please indicate the overall level of functioning and satisfaction with each of the following areas during the past month. Refer to the scale below:

1 Very dissatisfied / Very dysfunctional
2 Dissatisfied / Dysfunctional
3 Neither dissatisfied nor satisfied
4 Satisfied / Functional
5 Very satisfied / Very functional
N/A Non applicable

01. Work/School..... 1 2 3 4 5 N/A
02. General mood..... 1 2 3 4 5 N/A
03. Relationship with your romantic partner. 1 2 3 4 5 N/A
04. Relationship with your children..... 1 2 3 4 5 N/A
05. Relationship with your mother..... 1 2 3 4 5 N/A
06. Relationship with your father..... 1 2 3 4 5 N/A
07. Relationship with your siblings..... 1 2 3 4 5 N/A
08. Relationship with friends..... 1 2 3 4 5 N/A
09. Finances..... 1 2 3 4 5 N/A
10. Sexual life..... 1 2 3 4 5 N/A
11. Spiritual life..... 1 2 3 4 5 N/A
11. Leisure time activities..... 1 2 3 4 5 N/A
12. Excitement/challenge..... 1 2 3 4 5 N/A
13. Living/housing situation ..... 1 2 3 4 5 N/A
14. Occupational accomplishments..... 1 2 3 4 5 N/A
15. Health..... 1 2 3 4 5 N/A

EXPECTATIONS ABOUT THERAPY AND YOUR THERAPIST

What would you like to accomplish in therapy? How would like your life to be different?_____
_____
_____
_____

Use the following scale to indicate the estimate probability to solve your problem through psychotherapy.

None____ Low/Little____ Moderate____ High____ Very high____

What personal and professional qualities do you expect from your therapist?
_____
_____

OBSERVATIONS AND COMMENTS

Please indicate any other additional information that you consider important for me to know about you.

_____

_____

_____