**º BACKGROUND INFORMATION** NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_12/18

Briefly describe why you are here:

­­­­­­­­­­­­­­­­­

What are your goals for therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem: [ ] mild [ ] moderate [ ] severe

Does the problem affect: [ ] Work  [ ] Relationships  [ ] Health

Have there been recent changes in: [ ] Weight +/-\_\_\_\_\_\_\_\_lbs. [ ] Appetite +/-  [ ] Sleep +/-

**Anxiety:** [ ]  mild [ ]  moderate [ ]  severe **Depression:** [ ]  mild [ ]  moderate [ ]  severe

PLEASE IDENTIFY THE PROBLEMS:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_ energy  | \_\_\_\_\_ making decisions | \_\_\_\_\_ certain thoughts | ­­­­\_\_\_\_\_ hallucinations |
| \_\_\_\_\_lack joy | \_\_\_\_\_ guilt  | \_\_\_\_\_ loneliness | \_\_\_\_\_ stepfamily |
| \_\_\_\_\_ memory | \_\_\_\_\_ mood swings | \_\_\_\_\_ motivation | \_\_\_\_\_ drugs |
| \_\_\_\_\_ withdrawal | \_\_\_\_\_ panic attacks | \_\_\_\_\_ separation | \_\_\_\_\_ divorce |
| \_\_\_\_\_ sadness | ­­­­\_\_\_\_\_ fears/phobias | \_\_\_\_\_ shyness  | \_\_\_\_\_ marriage |
| \_\_\_\_\_ crying spells | ­­­­\_\_\_\_\_ excessive worry | \_\_\_\_\_ grief | \_\_\_\_\_ parenting |
| \_\_\_\_\_ concentration | \_\_\_\_\_ nightmares | \_\_\_\_\_ headaches | \_\_\_\_\_career issues |
| \_\_\_\_\_ low self-esteem | \_\_\_\_\_ self-control | \_\_\_\_\_ stomach/bowel | \_\_\_\_\_ sexual |
| \_\_\_\_\_ irritability | \_\_\_\_\_ relaxation | \_\_\_\_\_ sleep difficulties | \_\_\_\_\_\_appetite \_\_\_\_\_\_legal issues |

**PLEASE RESPOND TO THE FOLLOWING**:

How much and how often do you drink alcohol?\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use street drugs?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever think of harming yourself or others? [ ] **Yes**- [ ] self [ ] others. [ ] **No**

Have you ever acted on these thoughts? [ ] **Yes**  [ ] No

**Explain**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any history of childhood abuse? [ ]  Verbal [ ]  Emotional [ ]  Physical [ ]  Sexual

By whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been arrested?\_\_\_\_\_\_\_\_\_\_\_Any pending legal issues?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE IDENTIFY THE CURRENT STRESSORS IN YOUR LIFE:**

[ ]  **Problems with your primary support group**. *example*: disruption in family by separation or divorce, health problems or loss of a family member, emotional, physical or sexual abuse.

[ ]  **Problems related to the social environment**. *example* Death or loss of a friend, inadequate social support, living alone, discrimination, adjustment to life-cycle transition (e.g., retirement).

[ ]  **Occupational or Educational problems**. *example* Unemployment, threat of job loss, stressful work schedule, difficult work conditions, job dissatisfaction, job change, discord with boss or coworkers, illiteracy, academic problems, discord with teachers/professors or classmates.

[ ]  **Financial** problems.

[ ]  **Housing** problems. *example* housing, unsafe neighborhood, discord with neighbors or landlord

[ ]  **Problems with access to health care services**. *example* Inadequate health care services, inadequate health insurance.

[ ]  **Interaction with legal system/crime**. *example* Victim of crime, litigation, arrest or incarceration

**Other**: *example* exposure to disaster, conflict with non-family caregivers.

**PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING AND FAMILY** **MEMBERS WITH EMOTIONAL OR PSYCHIATRIC PROBLEMS:**

NAME RELATION AGE MEDICAL/PSYCIATRIC

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PLEASE PROVIDE INFORMATION ON PREVIOUS TREATMENT THAT YOU HAVE RECEIVED. Include hospitalizations and counseling. Provide prescription information as well as the names of therapists or doctors and dates, if possible

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_