



**FAMILY BACKGROUND:**

Please list the members of your current family, including ages, occupations, and any comments about them or comments about your relationship with them:

Name	Relationship	Age	Occupation	Comment(s)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list members of extended family that are key figures in your life (examples: siblings, parents, grandparents, etc):

Name	Relationship	Age	Occupation	Comment(s)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please check and explain any past, present, or impending family issues:

- Deaths \_\_\_\_\_  Divorce \_\_\_\_\_
- Financial Crisis \_\_\_\_\_  Injuries/Illness \_\_\_\_\_
- Abuse \_\_\_\_\_  Other \_\_\_\_\_

Has anyone in your family ever had:

- Psychiatric problems (depression, anxiety, psychosis, etc)?  Yes  No  Unsure
- Unhealthy alcohol or drug use?  Yes  No  Unsure
- An attempted or completed suicide?  Yes  No  Unsure

**LEGAL BACKGROUND:**

Do you have any current, pending, or future legal issues?  Yes  No  Unsure

If 'Yes' or 'Unsure,' please explain: \_\_\_\_\_

\_\_\_\_\_

**MEDICAL AND HEALTH BACKGROUND:**

Do you have any current medical problems?  Yes  No If 'Yes,' please describe below:

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

Are you currently taking any medications?  Yes  No If 'Yes,' please list below:

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

Have you been hospitalized or treated for serious medical problems in the past?  Yes  No

Who is your regular health care provider? \_\_\_\_\_  
(Note: We will not contact this person without your authorization, except in case of emergency)

Are you having any trouble with your sleep?  Yes  No If 'Yes,' explain below.

- Difficulty falling asleep       Sleeping too much       Waking up during night
- Disturbing dreams       Sleeping too little       Not feeling refreshed

Are you having any difficulties with your appetite or eating habits?  Yes  No If 'Yes,' explain below.

- Eating less     Eating more     Restricting     Binging or out-of-control eating     Diminished appetite

Do you currently drink alcohol?  Yes  No      Have you drank alcohol in the past?       Yes  No

Do you currently use any drugs?  Yes  No      Have you tried or used drugs in the past?       Yes  No

How many times per week do you exercise? \_\_\_\_\_      How long each time? \_\_\_\_\_

What type(s) of exercise? \_\_\_\_\_

How do you relax yourself? \_\_\_\_\_

**RELATIONSHIPS:**

Are you currently involved in an intimate relationship?  Yes  No  Unsure

If 'Yes' or 'Unsure:' Name: \_\_\_\_\_ How Long: \_\_\_\_\_

Who do you hang-out with most often? \_\_\_\_\_

Who do you talk with about serious things in your life? \_\_\_\_\_

Who is aware of the problem(s) you are having? \_\_\_\_\_

Who is critical of you? \_\_\_\_\_

**STRENGTHS AND LIKES:**

Which areas of your life are going well? \_\_\_\_\_

Favorite hobbies or activities: \_\_\_\_\_

Favorite movies, books, or TV shows: \_\_\_\_\_

**PSYCHOLOGICAL BACKGROUND:**

Are you currently seeing another psychologist, psychiatrist, or therapist?  Yes  No

Have you ever seen a psychologist, psychiatrist, or therapist in the past for any reason?  Yes  No

Are you currently having thoughts about ending your life or wanting to die?  Yes  No

Have you had thoughts about ending your life or wanting to die in the past 3 months?  Yes  No

Have you ever attempted to kill or harm yourself in the past?  Yes  No

Are you currently having thoughts about wanting to hurt or harm somebody else?  Yes  No

Have you ever been involved in a physical fight or hurt somebody in the past?  Yes  No

Have you ever been a victim of rape or received unwanted sexual contact?  Yes  No  Unsure

Have you ever been exposed to physical abuse, emotional abuse, or other trauma?  Yes  No  Unsure

Have you ever witnessed a horrific or terrifying experience (e.g. death)?  Yes  No  Unsure

**PROBLEM DESCRIPTION:**

Briefly describe the problem(s) for which you are seeking help:

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

How long have you been dealing with the problem(s)? \_\_\_\_\_

How has your relationships, work, or sense of well-being been affected by the problem(s)? \_\_\_\_\_

\_\_\_\_\_

How have you tried to fix or cope with the problem(s)? \_\_\_\_\_

\_\_\_\_\_

What are your treatment goals for the problem(s)? \_\_\_\_\_

\_\_\_\_\_