INDIVIDUAL QUESTIONNAIRE

The information you give in this questionnaire is strictly confidential. Please fill it out as thoroughly as possible. This will assist us in the process of identifying your concerns and your goals for therapy.

Name: _____ Date: _____

Current Concerns

Check the items that describe or relate to the concerns you have now:

- ☐ Grief
- ☐ Depression
- ☐ Anxiety
- ☐ Panic
- ☐ Fear
- ☐ Self-doubt
- ☐ Intense anger
- ☐ Insecurity
- ☐ Guilt
- ☐ Unusual feelings
- ☐ Suicidal feelings/thoughts
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Sleeplessness
- ☐ Troubled dreams
- ☐ Too little/too much energy
- ☐ Too little/too much appetite
- ☐ Alcohol or drug use (self)
- ☐ Alcohol or drug use (other)
- ☐ Sexual concerns
- ☐ Impotency/frigidity
- ☐ Illness of self
- ☐ Infertility or miscarriage
- ☐ Loss of faith in self
- ☐ Loss of hope
- ☐ Loss of meaning
- ☐ Loss of self-respect
- ☐ Vocational direction
- ☐ Abuse (physical, sexual, emotional) – current or past
- ☐ Infidelity of self
- ☐ Infidelity of spouse
- ☐ Partner problems
- ☐ Relationship w/parents
- ☐ Relationship w/children
- ☐ Relationship w/in-laws
- ☐ Relationship with authority
- ☐ Loss of faith in others
- ☐ Loss of love
- ☐ Illness of relative
- ☐ Religious doubts and fears
- ☐ Anger with God
- ☐ Loss of faith in God
- ☐ Other: _____
- ☐ Other: _____

These concerns have existed for (time): _____

Since they started, have your concerns: ☐ Stayed the same? ☐ Improved? ☐ Worsened?

What do you feel are the causes of your concerns?_____

_____

What are the specific concerns you want to work on in therapy?

1._____ 2._____

3._____ 4._____

These concerns would improve if:_____

_____

What have you done up to this point to deal with these concerns?_____

_____

What are your reasons for addressing these concerns in counseling at this particular time?_____

_____

On the scale below, rate the extent that you believe you can be helped to solve these concerns:

1	2	3	4	5	6	7
Little Confidence That I Can Be Helped		Some Confidence That I Can Be Helped		Fairly Confident That I Can Be Helped		Very Confident That I Can Be Helped

Developmental History

When were you born? _____ Were there any complications? Please explain:_____

_____

Are you adopted or a foster child? ☐ Yes ☐ No

If yes, when were you adopted and how old were you?_____

If you were adopted or in foster care, what do you know about your biological parents?_____

_____

What is your earliest childhood memory?_____

_____

Check any of the following childhood experiences which apply to you:

☐ Bedwetting
☐ Soiling
☐ Nightmares
☐ Night terrors
☐ Temper tantrums
☐ Tics
☐ Crying spells
☐ Thumb sucking
☐ Other: _____
☐ Other: _____

☐ Stuttering
☐ Daydreaming
☐ Shyness
☐ Overweight
☐ Slow talking
☐ Fear of playmates
☐ Imaginary friends
☐ Learning good toilet habits

☐ Learning problems
☐ Sleepwalking
☐ Nail biting
☐ Excessive fighting
☐ Slow physical development
☐ Repeated vomiting
☐ Bowel problems

Please explain any checked items more fully. In particular, how did these experiences impact on you?_____

_____

_____

What other significant factors, events or experiences in your development would be important for your counselor to know about, and how did these impact on you?_____

_____

Health History

What is your current height?_____ Your current weight? _____ Any recent weight changes? ☐ Yes ☐ No
If yes, please explain: _____

When was your last physical check-up? _____ What were the results? _____

_____

Please complete the following checklist of health concerns **by circling**
"R" for Regularly, "O" for Occasionally, "S" for Seldom, and "N" for Never.

R O S N	Nervousness	R O S N	Weight Problems
R O S N	Grinding of teeth	R O S N	Sleeping Problems
R O S N	Chest Pains	R O S N	Nausea
R O S N	Headaches	R O S N	Diarrhea
R O S N	Clenching of Jaw	R O S N	Loss of Appetite
R O S N	Skin Problems	R O S N	Exaggerated Appetite
R O S N	Exhaustion	R O S N	Heart Racing
R O S N	Chronic Pain	R O S N	Shortness of Breath
R O S N	Colds/flu	R O S N	Cold hands/feet
R O S N	Persistent Cough	R O S N	High Blood Pressure
R O S N	Allergy/sinus	R O S N	Colitis
R O S N	Sexual Difficulties	R O S N	Migraine Headache
R O S N	Muscle tension/cramps	R O S N	Other: _____
R O S N	Indigestion	R O S N	Other: _____

List any traumatic or unusual diseases, illnesses, or accidents which you have had as a child, teen, or adult *(please include your age and dates of occurrence)*: _____

_____

Are there any hereditary diseases in your family? If yes, please describe: _____

_____

Have you or any member of your family been involved in psychotherapy or been in the hospital for psychiatric reasons? If yes, please describe: _____

_____

Do you have any physical impairments, scars, or disfigurements which concern you? If yes, please explain: _____

_____

List all current medications and reason for taking: _____

_____

_____

Please complete the following by recording the appropriate information and circling the appropriate frequency code.
Please fill out each item. **1 = Daily 2 = Weekly 3 = Monthly 4 = Occasionally 5 = Seldom 6 = Never**

	Age First Used	Age Last Used	Frequency Code	Quantity
Tobacco	_____	_____	1 2 3 4 5 6	_____
Caffeine	_____	_____	1 2 3 4 5 6	_____
Alcohol	_____	_____	1 2 3 4 5 6	_____
Weight Loss	_____	_____	1 2 3 4 5 6	_____
Sleeping	_____	_____	1 2 3 4 5 6	_____
Narcotics	_____	_____	1 2 3 4 5 6	_____
Marijuana	_____	_____	1 2 3 4 5 6	_____
Cocaine/Coke	_____	_____	1 2 3 4 5 6	_____
Hallucinogens	_____	_____	1 2 3 4 5 6	_____
Other: _____	_____	_____	1 2 3 4 5 6	_____
Other: _____	_____	_____	1 2 3 4 5 6	_____

Does your use of the above items interfere with your home, social, work, or school life? ☐ Yes ☐ No
If yes, please explain:_____

_____

Do you have "after effects" from your use of any of the above substances? ☐ Yes ☐ No
If yes, please explain:_____

_____

Sexual History

When, how, and from whom did you first learn about human sexuality?_____

_____

_____

With whom were you able to talk about human sexuality?_____

What were the attitudes toward human sexuality which were communicated to you, and by whom?_____

_____

Have you had any unusual, unpleasant, or frightening sexual experiences? ☐ Yes ☐ No If yes, please explain:_____

_____

Has your sex life been fulfilling and satisfying? ☐ Yes ☐ No If no, what do you see as the reasons for this?_____

_____

For Women Only

What was the age of your first menstrual cycle (period)?_____

Were you prepared? ☐ Yes ☐ No

How did it affect you?_____

Have you experienced any menstrual pain or irregularity? ☐ Yes ☐ No

If yes, please explain: _____

Do periods affect your mood? ☐ Yes ☐ No

If yes, how? _____

If you have been pregnant, have there been any complications? ☐ Yes ☐ No

If yes, what and how have these complications affected you? _____

_____

Have you undergone or are you about to undergo menopause? ☐ Yes ☐ No

If yes, when and how has it affected you?_____

If your mother has experienced menopause, how did it affect her? How did this affect you?_____

_____

_____

FAMILY DATA

Please include relatives whether living or deceased-if deceased give approximate date of death and list any non-family members living in household

	Name	Age	Sex	Living/ Dcsd	Marital Status	Occupation	Resides	Feel Close to/ Distant From Circle1(C)to7(D)
Spouse								1 2 3 4 5 6 7
Children								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
Father								1 2 3 4 5 6 7
Mother								1 2 3 4 5 6 7
Brothers and/or Sisters								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
Others: Step-sibs, Ex-Spouse, Etc.								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7
								1 2 3 4 5 6 7

Relational History

Briefly describe your mother:_____

_____

Briefly describe your father:_____

_____

Please circle the best fitting choice.

Our home was:

Very Happy Happy Unhappy Very Unhappy

In comparison with your siblings, were you disciplined:

Much More More Same Less

Were your parents:

Very Strict Strict Not Strict Lenient Inconsistent

As a parent, was your mother:

Excellent Good Poor Very Poor

As a parent, was your father:

Excellent Good Poor Very Poor

In what ways and how often were you disciplined and rewarded?_____

_____

How were you taught to deal with and express emotions in your family?_____

_____

What did your family value most about you?_____

_____

Were your parents divorced or separated? ☐ Yes ☐ No

If yes, how old were you, what were the circumstances, and how did it affect you?_____

_____

With whom did you live after the divorce?_____

_____

Did either of your parents remarry? ☐ Yes ☐ No If yes, which parent/s and how old were you?_____

_____

How do/did you get along with your step-parent(s)?_____

_____

If you are currently married or involved in a long-term living together relationship, when did you get married/started living together?_____

How long did you know each other before getting married/living together?_____

How did you meet and what attracted you to each other?_____

_____

How was the decision made to get married/start living together?

If you have children, how was the decision made and what was pregnancy like?

If you have children, what has been like to be a parent (singly or jointly)?

If you previously have been married or living with a significant other, please explain when, length of relationship and reasons for ending?

(Please list any children from these relationships on the Family Data page - page number 6 - include ex-partners if relevant.)

Describe your peer group or friendship relationships growing up as well as in your adult years:

What other significant relationships (relatives, teachers, etc.) have you had in your life and what impact have these persons had on you?

Have you lost anyone close to you through death? ☐ Yes ☐ No If yes, whom did you lose, how old were you at that time, how did this person die, how did you react?

When you consider the above information, what have you learned from the relationships in your life?

In your opinion, what do other people think of you at this point in your life?

How would you like to change your relational life?

Use the space below for any additional information relevant to the above questions or to share any additional information about your relationships that you believe would be helpful to your counselor.

Educational History

At what age did you start school? _____

What was the last grade you completed? _____

At what age did you complete this grade? _____

How many grammar schools did you attend? _____

Were you ever in special classes? ☐ Yes ☐ No

Did you attend classes for: ☐ Remedial Reading ☐ Remedial Math ☐ Honors/AP
☐ Speech Therapy ☐ Coordination ☐ Gifted
☐ Handwriting ☐ Behavior Problems ☐ Other:_____

Please explain:_____
_____

Did you have other special difficulties or concerns in school? ☐ Yes ☐ No
If yes, please explain:_____

Overall, how did you feel about school?_____
_____

Occupational History

Please list below your employment history, beginning with your current or most recent job:

Employed By:	Type of Work:	How Long:	Left Because:

Were you ever fired? ☐ Yes ☐ No
If yes, please explain:_____

Has your job situation changed in the last five years? ☐ Yes ☐ No
If yes, please explain:_____

In the past five years, has your income ☐ increased, ☐ decreased, or ☐ stayed the same?

Legal Information

Please check in any current or past legal concerns:

☐ Driving Offenses ☐ Financial ☐ Family ☐ Violence ☐ Immigration

☐ Other: _____

Please explain: _____

_____

Have you been arrested or imprisoned? ☐ Yes ☐ No
If yes, please explain: _____

Are you involved in any legal actions now? ☐ Yes ☐ No
If yes, please explain: _____

Spirituality, Faith, and Religion

If you were raised in a particular spiritual, faith, or religious tradition, please describe this tradition and how it affected you? _____

_____

_____

Has your understanding and experience of spirituality, faith and religion changed since you were a child? If so, how? _____

_____

_____

If you have any current spiritual, faith, and religious orientation and practices, how would you describe them? _____

_____

_____

How do your current spiritual, faith and religious orientation and practices help you or hinder you in dealing with your concerns?

_____

_____

_____

If you believe in God, how have your concerns impacted your beliefs? _____

_____

_____

Are there any "meaning in life" questions your current situation has raised for you? _____

_____

_____

From what resources do you draw strength and courage to go on? _____

_____

_____

Where do you find peace in your life? _____

_____

When do you feel most connected to yourself, others, and God *(if you believe in God)*? How do you cultivate those deep connections?

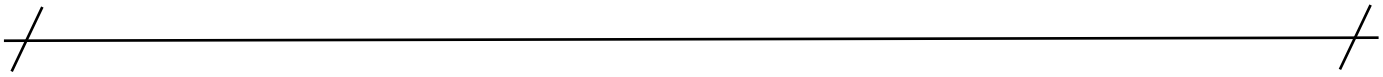
What legacy would you like to leave behind in your life or how would you like people to remember you?

Closing Thoughts

Is there any additional information about yourself that would help your counselor understand you as a person?

Optional: If you believe it would be helpful, please use the space below to create a timeline of the significant events in your life that would be important for your counselor to be aware of.

Date:



Birth Present

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONAIRE!