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

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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: __________________________

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

☐ 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.

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<th>Nervousness</th>
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<th>Weight Problems</th>
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<th>Grinding of teeth</th>
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<th>Sleeping Problems</th>
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<th>Clenching of Jaw</th>
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<th>Diarrhea</th>
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<th>Skin Problems</th>
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<th>Exaggerated Appetite</th>
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<th>Exhaustion</th>
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<th>Heart Racing</th>
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<th>Chronic Pain</th>
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<th>Colds/flu</th>
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<th>Cold hands/feet</th>
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<th>Persistent Cough</th>
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<th>High Blood Pressure</th>
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<th>Allergy/sinus</th>
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<th>Colitis</th>
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<th>Sexual Difficulties</th>
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<th>Migraine Headache</th>
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<th>Muscle tension/cramps</th>
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<th>Indigestion</th>
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<th>Other: ____________________</th>
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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

<table>
<thead>
<tr>
<th>Item</th>
<th>Age First Used</th>
<th>Age Last Used</th>
<th>Frequency Code</th>
<th>Quantity</th>
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<td>Tobacco</td>
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<td>Caffeine</td>
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<td>1 2 3 4 5 6</td>
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<tr>
<td>Alcohol</td>
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<td>1 2 3 4 5 6</td>
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<td>Weight Loss</td>
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<td>1 2 3 4 5 6</td>
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<td>Sleeping</td>
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<tr>
<td>Narcotics</td>
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<td>1 2 3 4 5 6</td>
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<tr>
<td>Marijuana</td>
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<td>1 2 3 4 5 6</td>
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<tr>
<td>Cocaine/Coke</td>
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<td>1 2 3 4 5 6</td>
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<tr>
<td>Hallucinogens</td>
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<tr>
<td>Other:</td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td>1 2 3 4 5 6</td>
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</table>

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? _________________________________
_____________________________________________________________________________________________________________________________________

SamaraCare Counseling  1819 Bay Scott Circle  Suite 109, Naperville, IL 60540  
Phone 630-357-2456  Fax 630-357-2482  4
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.

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

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<tr>
<th>Employed By:</th>
<th>Type of Work:</th>
<th>How Long:</th>
<th>Left Because:</th>
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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 QUESTIONNAIRE!