Personal Data and History Questionnaire

The purpose of this inventory is to obtain a comprehensive picture of your background. In psychotherapy records are necessary since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your treatment planning. You are requested to answer these routine questions in your own time instead of using up your therapy time. As with all records, these are strictly confidential.

General Information

Date ____/____/_____ Name _____ DOB____/____/_____

Maiden/Other Names:_____ Gender: M F Social Security #_____

Address _____

Mailing address (if different from above) _____

Phone #'s: Home_____ Work_____ Mobile_____

E-mail _____

Emergency contact _____ Ph.# _____ Relationship _____

Employment status ___Full-time ___Part-time ___Homemaker full-time ___Unemployed (since_____)
___Not in labor force (e.g., student) ___Disabled (why?_____)

Employer:_____ Occupation_____

Highest year of education completed_____ Previous jobs held:_____

Cultural Identity __Anglo-Amer ___African-Amer. ___Hispanic ___Asian ___Native Amer.

Sexual orientation (optional): ___Heterosexual ___Bisexual ___Gay/lesbian ___Uncertain

Marital status: ___Single ___Married ___ Remarried ___Separated ___Divorced ___Widowed
When did any of these occur?_____

With whom do you live now? (names & relationships)_____

_____

Primary care physician _____ Phone # _____

Who referred you to me?_____

Description of Presenting Problems:

What is the nature of your main problems:

How severe would you rate them?
Mild upsetting; Moderately upsetting; Very severe; Extremely severe; Totally incapacitating

When did your problems begin?

What seems to worsen your problems?

How satisfied are you with our life as a whole these days? (Not satisfied) 1 2 3 4 5 (Very satisfied)

How would you rate your overall level of tension during the past month? (Relaxed) 1 2 3 4 5 (Tense)

What have you tried that has been helpful?

Expectations Regarding Therapy:

In a few words, what do you think therapy is all about?

How long do you think your therapy should last?

How strongly do you want treatment? ___very much ___much ___moderately ___not much ___not at all

What personal qualities do you things the ideal therapist should possess?

Psychiatric History (List who provided, when, and for what issues)

	Who/Where	Dates	Issues
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Have you had any hospitalizations for psychological problems? If yes, please describe_____

_____

Have you ever made a suicide attempt? If yes, please elaborate when, how, and why_____

_____

Has anyone in your family had psychological or substance abuse problems? If yes, please describe_____

_____

Have any relatives committed suicide? If yes, when, how, and why?_____

_____

Family History:

Father's Name: Age: Occupation:
Health:
Mother's Name: Age: Occupation:
Health:
Siblings: Name/Age Quality of Relationship:

Description of father's personality and his attitude toward you (past & present)

Description of mother's personality and her attitude toward you (past & present)

How were you disciplined or punished by your parents?

What was the home environment and communication like at home?

Were you able to confide in your parents? Did you feel loved and respected?

Did parents ever divorce and remarry? Step-parents???

Did any of the following apply during childhood or adolescence?

- Happy childhood / Unhappy childhood
- Emotional / Behavioral Problems
- Legal trouble
- Death in the family
- Medical problems
- Ignored / neglected
- Abused: Sexually, Physically, Verbally
- Academic problems
- Severely bullied or teased
- Not enough friends
- Financial problems
- Eating disorder
- Strong religious convictions
- Drug / Alcohol use (by anyone)
- Severely punished

School History:
Strengths: Weaknesses:

Last grade completed:

Extracurricular activities?

Interpersonal History:

Do you make friends easily? Do you keep them usually?

Did you date much in highschool? College?

Were you ever bullied or teased?

How relaxed or comfortable do you generally feel in social situations: (Very relaxed) **1 2 3 4 5** (Very anxious)

Do you have one or more friends with whom you feel comfortable sharing your private thoughts?

Any problems in your relationships with coworkers? If yes, please describe:

Marriage (or committed relationship)(if applicable):
How long did you know your S.O.(significant other) before your engagement?

How long was your engagement?

How long have you been married?

Spouse's age? His/Her occupation?

Describe his/her personality?

What do you like most about your S.O.?

What do you like least about your S.O.?

How satisfied are you with your marriage?

What factors detract from your marital satisfaction?

How do you get along with your S.O.'s friends/family?

Previous marriages? If so, please describe duration and circumstances of divorce?

Are you currently troubled by any past rejections or loss of a love relationship?

Children:
Names & Ages:

Do any of your children present any special problems/needs? If yes, please describe:

Sexual History:
Is your present sex life satisfactory? If no, please describe:

Describe your parents' attitude toward sex. Was sex discussed in the home?

When and how did you acquire your knowledge of sex?

Medical History:

Please list any current medical problems or health concerns_____

_____

_____

Please list all medications you currently use, both prescribed and non-prescribed:

Name of medication	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle any of the following currently apply to you:

Weight Loss / Weight Gain Poor Appetite / Big Appetite Vomiting / Purging
Overeat / Binging Undereat / Anorexia
Diarrhea / Nausea / Constipation Indigestion / Gas / Bloating Urinary problems
Fitful sleep / Early awakenings Insomnia / Sleep too much Hair loss
Fast heartbeat / Palpitations Shortness of breath Chest pain
Dizziness / Fainting spells Tingling in hands or feet Tremor
Muscle weakness / Fatigue Headaches / Aches Chronic pain & discomfort
Deafness Blurred vision
Ringing in ears
Problems with sexual organs Menstrual problems Dry skin

Do you get regular physical exercise? If yes, what type and how often?_____

Have you had any hospitalizations for medical reasons? If yes, please describe_____
_____

Please mark if you or any blood relatives have had any of the following (Mark **Y** for you and **R** for relative):

__Cancer __Miscarriage __Allergies
__Heart trouble
__Thyroid problem __High blood pressure __Diabetes __Neurological disease
__Kidney trouble __Epilepsy/seizures __HIV positive __Eye trouble
__Abortion __Head injury __Other hormonal illness

Menstrual History (if applicable):

Age of first period:

Are you currently regular?Duration: Do you have pain?

Do your periods affect your moods?

Pregnant now? __Yes __No __Unsure (If yes, due date:_____)

Date of last period:

Alcohol and Drug History:

In the last year, have you ever drunk or used drugs more than you meant to? __Yes __No

Have you felt you wanted or needed to cut down on your drinking or drug use in the last year? __Yes __No

Any drug or alcohol related arrests? __No __Yes Ever had D.T.'s (delirium tremens)? __No __Yes

Any blackouts from drugs or alcohol? __No __Yes Ever injected drugs? __No __Yes

How many cigarettes, if any, do you smoke in a day?_____

How much coffee or drinks with caffeine do you drink in a day?_____

Please check which of the following substances you have used:

	When began use?	Month/Year last used?	How often /How many?
Alcohol		_____	_____
Inhalants/Glue	_____	_____	_____
Marijuana		_____	_____
Amphetamines/Speed	_____	_____	_____
Barbiturates/Downers	_____	_____	_____
Valium, Xanax, etc.	_____	_____	_____
Psychedelics/LSD, etc.	_____	_____	_____
Cocaine/Crack	_____	_____	
Heroin/Opiates	_____	_____	
Pain or Sleeping Pills	_____	_____	_____
Diet Pills/Laxatives	_____	_____	

Religious/Spiritual:

What was your religious upbringing?_____

What do you currently practice?_____

Trauma history: (Check any that apply and elaborate below)

__Minor/major car accidents __Invasive medical/dental procedures __Falls
__Natural disasters __Illnesses involving high fever
__Accidental poisoning
__Abandonment __Prolonged immobilization, e.g, casting __Difficult birth
__Emotional abuse __Exposure to extreme heat or cold __Parental divorce

__Physical abuse __Catastrophic injury
__War trauma
__Witnessing domestic violence __Other_____

Is there anything else you would like to tell me?

This last section is designed to help you describe our current problems in greater detail and to identify problems that might otherwise go unnoticed. This will enable us to tailor your treatment best to your specific needs.

BEHAVIORS:

Circle any of the following that apply to you (at least sometimes):

Eating problems Loss of control Phobic Avoidance Crying Taking Drugs Suicide attempts Spend too much money Outbursts of temper Unassertive Compulsions Can't keep a job
Odd behavior Smoke Insomnia Drink too much Withdrawal/isolation Lazy
Work too hard Nervous tics Procrastination Concentration difficulties Aggressive behaviors
Take too many risks Others:_____

What are some special talents or skills that you feel proud of?

What would you like to start doing?

What would you like to stop doing?

How is your free time spent?

What kind of hobbies or leisure activities do you enjoy or find relaxing?

Do you have trouble relaxing or enjoying weekends and vacations? If yes, please explain.

If you could have any two wishes, what would they be?

FEELINGS:

Circle any of the following feelings that often apply to you:

Angry Fearful Anxious Happy Contented Hopeful Optimistic
Panicky Sad / Depressed
Conflicted Helpless Hopeless Restless Bored
Tense Energetic Excited Shameful Relaxed Lonely
Annoyed Envious Jealous Guilty Regretful Unhappy
Others_____

List your five main fears:

What are some positive feelings you have experienced recently:

When are you most likely to lose control of your feelings?

Describe any situations that make you feel calm or relaxed:

SELF IMAGE:

Circle any of the following that apply to you. I see myself (at least sometimes):

Being happy Being talked about Being trapped Being hurt
Being aggressive Not coping
Being laughed at Being helpless Being promiscuous Succeeding Hurting others Losing control
Being in charge Being followed Failing Other_____

I have (at least sometimes):

Pleasant sexual images Seduction images Unpleasant childhood images
Images of being loved
Negative body image Unpleasant sexual images Lonely images
Others:_____

Describe a very pleasant image, mental picture or fantasy:

Describe a very unpleasant image, mental picture or fantasy:

Describe any persistent or disturbing images that interfere with your daily functioning:

How often do you have nightmares?

THOUGHTS:

Circle each of the following that you might use to describe yourself:

Intelligent Confident A nobody Inadequate Useless
Confused Worthwhile Evil Ambitious Sensitive
Crazy Worthless Ugly Stupid Can't make decisions Naïve
Loyal Morally degenerate Suicidal ideas Considerate Trustworthy
Deviant Full of regrets Unattractive Honest Incompetent
Concentration difficulties Memory problems Attractive Persevering Good sense of humor Horrible thoughts Unlovable Conflicted
Undesirable Untrustworthy Dishonest Lazy Hard working

What do you consider to be your craziest thought or idea?

Are you bothered by thoughts that occur over and over again? If yes, what are these thoughts?

What worries do you have that may negatively affect your mood or behavior?

<u>On each of the following items, please circle the number that most accurately reflects your opinion</u>

Strongly disagree = 1 Disagree = 2 Neutral = 3 Agree = 4 Strongly Agree = 5

I should not make mistakes
1 2 3 4 5
I should be good at everything I do
1 2 3 4 5
When I do not know something, I should pretend that I do
1 2 3 4 5
I should not disclose personal information
1 2 3 4 5
I am a victim of circumstance
1 2 3 4 5
My life is controlled by outside forces
1 2 3 4 5
Other people are happier than I am
1 2 3 4 5
It is very important to please other people
1 2 3 4 5
Play it safe, don't take any risks
1 2 3 4 5

I don’t deserve to be happy

1 2 3 4 5

If I ignore my problems, they will all disappear

1 2 3 4 5

It is my responsibility to make other people happy

1 2 3 4 5

I should strive for perfection

1 2 3 4 5

Basically, there are two ways of doing things – the right way and the wrong way 1 2 3 4 5

I should never be upset

1 2 3 4 5