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PSYCHOTHERAPY SELF ASSESSMENT FORM

The information in this self-assessment is for the use of your therapist in the evaluation process. All material contained in this questionnaire will remain confidential. I know it's long, but it will save us time and help me with your treatment, if you complete it. That means you will feel better faster. Hang in there and just do it!
When you complete this form, please:
(1) answer all questions that apply as fully as possible; print or write clearly; skip questions that don't apply.
(2) be as specific as possible in regard to names, dates, ages, etc.
(3) write on the back side of the paper, if you need more space
(4) be sure to **complete this first page of demographic information and the symptom checklist on page two**. That's the most important part of the assessment and can't be skipped.

NAME _____ DATE _____
(First, Last, Middle or Maiden)
ADDRESS _____
(Number and Street) *(Town)* *(State)* *(Zip)*
TELEPHONE _____
Home _____ Work _____
AGE _____ DATE OF BIRTH _____ SS# _____
PLACE OF BIRTH _____
(Town) (State) (Country)
REFERRED BY _____
Name of person to call in an emergency _____
Relationship to you _____
Address_____
Phone Number (Home) _____
(Work) _____ (Cell phone) _____
Primary Care Physician _____ Phone _____
What are your current living arrangements (check one)?
□ Single Family Home □ Multi-Family Home □ Apartment □ Dorm Other _____
Please list those people with whom you are currently living- Include: age, work, or school and your relationship:
_____ _____
_____ _____
_____ _____
Please list your main reason(s) for seeking help:
_____
_____
_____
How long has this problem (s) existed? _____
Has anything happened recently that made things worse? _____
_____

In the past two weeks, my problems have: □ Improved □ Stayed the same □ Worsened

Please check any symptoms you have and circle the most important symptoms:

□ depressed □ headaches □ feel inferior □ trouble breathing □ early morning awakening □ fast heartbeat □ can't sleep □ dizziness □ bowel disturbances □ fainting□ menstrual problems □ problems with sexual function or drive □sexual compulsion or addiction □ can't concentrate □ numbness or tingling □ can't make decisions □ racing thoughts□ feel hopeless □ unusual feelings □ feel tired □ hearing voices/ hallucinating □ lonely □ angry overambitious □ sleeping too much □ can't keep job □ legal problems □ family conflict □ financial problems □ nervous eating/ overeat compulsively/ weight gain □ lack of appetite/ not eating/ weight loss □ nausea/vomiting □ excessive gambling □ excessive drinking □ drugs □ can't relax □ feel panicky □ temper outbursts □ hands shake □ hearing difficulty □ feel tense □ difficulty communicating □ social isolation □ relationship problems □ trouble with authority □ shyness/social anxiety □ domestic violence □ history of being abused □ bullied □ cutting or self-mutilation □ confusion or memory loss □ major life change or stressor_____

□ other_____

□ feel suicidal (if yes, do you have a plan? □ yes □ no) plan: _____

□ feel like injuring someone else (if yes, do you have a plan? □ yes □ no) plan: _____

How long has this problem (s) existed? _____

What would you like to get out of coming for evaluation and treatment?

_____

_____

Please list any serious or hereditary diseases in your family:

_____

Do you have any physical impairments, scars, disabilities, or disfigurement? □ Yes □ No

If yes, explain: _____

MEDICAL (WOMEN)

Age of onset of periods: _____ Were you prepared physically and emotionally?_____

Please explain: _____

Do you ever experience any menstrual pain or irregularity? □ Yes □ No

Do periods affect your mood? □ Yes □ No

Explain: _____

Have there been any complications during or following your pregnancies? □ Yes □ No

If yes, please explain (include mood swings):

_____

Have you ever had any infertility, abortions, miscarriages, or stillbirths? If yes, please indicate which and give the date(s) and any other necessary information relevant to your care:

_____

_____

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

If yes, how has it affected you?

_____

MEDICAL HISTORY GENERAL

Rate your physical health (check one):

□ Excellent □ Good □ Average □ Declining □ Poor

Date of last physical check-up: _____

If problems were diagnosed, please describe:

_____

_____

Who is your Primary Care Provider or Family Physician?
Name _____
Address _____ Phone _____
Do you see a psychiatrist? □ Yes □ No If yes, does this psychiatrist know you are seeking therapy? □ Yes □ No
Name of Psychiatrist _____
If you are seeing a psychiatrist, please describe your reason for seeing psychiatrist and diagnosis:
_____
Psychiatrist's Address: _____
Psychiatrist's Phone: _____

Please list any other doctors or providers you are seeing, any medical conditions you are getting treatment for, and all medications you are taking for medical conditions. Please include supplements, herbal remedies, over the counter medication, prescriptions and any homeopathic or alternative treatments:
Doctor's Name *Medical Condition* *Medication or Treatment*
_____
_____
_____
_____

Your Height: _____ Weight: _____
Any Body Image Concerns?
_____
_____
_____

List all medications /drugs you use regularly or frequently, including herbs, vitamins, and over-the-counter medications as well as dosage and times of use:
Drug/Medication: Taken for: Dose: Frequency/Times: Taken as prescribed? Is it Helpful?
_____
_____
_____
_____
_____
_____

Do you have any allergies? □ Yes □ No
If yes, please explain:
_____
_____

Do you have any drug sensitivities? □ Yes □ No
If yes, please explain: _____
List all serious operations, injuries and hospitalizations you have had as a child, teenager, or adult:
_____
_____

List all serious diseases or illness you had as a child, teenager, or adult:
_____
_____
_____

Any long bed confinement(s)? □ Yes Age(s) _____ □ No
Have you had any of these medical problems? (check the ones that apply)
□ Seizures or Epilepsy □ Thyroid Problems □ Heart problems □ Fibromyalgia □ Hepatitis □ Asthma □ Anemia □ Chronic Pain □ Reproductive Problems □ Allergies to Medicines □ Glaucoma □ Urinary Problems □ Digestive Problems □ Diabetes □ Hypertension □ Hypotension □ Skin Conditions □ Arthritis □ Cancer
□ Other (Please specify): _____

Please describe your level of physical activity and daily amount of exercise: _____
_____
_____

CHILDHOOD AND FAMILY HISTORY
Describe your home life when you were growing up.

_____
_____
Have you ever lost a member of your family or someone close to you through death? □ Yes □ No
If so: whom did you lose, what was the date of the person's death, what was the cause of death, how did you react?

_____
_____
Were you reared by your birth parents? □ Yes □ No
Are your parents: □ separated □ divorced □ never married
Were you reared by: □ foster parents □ adoptive parents □ step parents
Is there anything your counselor should know about your parents:

_____
_____
Parents:
Name Father _____ Name Mother _____
Still living? (write in "yes' or "no") Father _____ Mother _____
Present age (write in ages) Father _____ Mother _____
Age at Marriage (write in ages) Father _____ Mother _____
Age at Death (write in ages) Father _____ Mother _____
Nationality Father _____ Mother _____
Religious Preference Father _____ Mother _____
Education (highest level) Father _____ Mother _____
Employment (describe job title) Father _____ Mother _____
If parents are living, are your parents living together? □ Yes □ No
Describe your parent's marriage: □ Unhappy □ Average □ Happy □ Very Happy
As a child did you feel closest to your (check one): □ father □ mother □ another
If another, please describe: _____
Rate your childhood life: □ Very happy □ Happy □ Average □ Unhappy
The person who had the greatest influence on my life is (describe influence as well):

_____
_____
_____
How were feelings expressed in your family?

_____
_____
How do you think your childhood experiences affect your situation today?

_____
_____
My mother favored: □ No one □ Me □ Brother □ Sister
My father favored: □ No one □ Me □ Brother □ Sister
My parents were: □ Very Strict □ Strict □ Not Strict □ Didn't Care
In what ways were you punished while growing up?

_____
_____
Do you feel you were abused by your parent(s): □ Yes □ No
Did you suffer from: □ physical abuse □ verbal abuse □ both
My father was: □ reserved □ very demonstrative of positive feelings □ withholding
□ critical and judging □ didn't care
My mother was: □ reserved □ very demonstrative of positive feelings □ withholding
□ critical and judging □ didn't care

Please, describe any fearful or distressing childhood experiences you have had, or anything noteworthy that was wonderful:_____
_____
What is your earliest memory?
_____
Please list your brothers and sisters in birth order:
(List half- or step-siblings in birth order following full blood brothers and sisters):
First Name Gender Age Living Marital Status(rate marriage of each)
_____ □ M □ F _____ □ Yes □ No □ Happy □ Average □ Unhappy □ Divorced
_____ □ M □ F _____ □ Yes □ No □ Happy □ Average □ Unhappy □ Divorced
_____ □ M □ F _____ □ Yes □ No □ Happy □ Average □ Unhappy □ Divorced
_____ □ M □ F _____ □ Yes □ No □ Happy □ Average □ Unhappy □ Divorced

EDUCATIONAL HISTORY
At what age did you start school? _____
Last grade, degree, and age completed _____
Did you ever have special abilities or difficulties? □ Yes □ No
If yes, please describe:
_____
_____
Did you attend special needs program(s)? □ Yes □ No
If yes, please describe:
_____
_____
Did you have any problems going to school? □ Yes □ No
If yes, explain:
_____
_____
Did you have any difficulty with teachers during your educational years? □ Yes □ No
Describe any pattern of difficulty with teachers:
_____
_____
How would you rate yourself on the following during growing up years?
(Please check appropriate box for each category)
ATHLETICS □ Active □ Average □ Less than Average □ None
GRADES □ Honor Roll □ Average □ Below Average □ Varied
POPULARITY □ Popular □ Average □ Unpopular □ Loner
DATING □ Popular □ Average □ Unpopular □ Loner
During your childhood did you tend to be a: □ leader □ follower □ loner
During your adolescence did you tend to be a □ leader □ follower □ loner

OCCUPATIONAL HISTORY
Are you currently employed? □ Yes □ No
If married, is your spouse employed? □ Yes □ No
If yes, please indicate the kind of work you do, the length of time you have held the job and your current position:
Kind of Work Time Held Job Current Position
Yourself: _____
Spouse: _____
If you have had a pattern of changing jobs, please describe your job history and pattern:
_____
If you or your spouse is currently unemployed, how long have you been unemployed?
Yourself: _____ Spouse: _____

MARITAL HISTORY
Marital Status: □ single □ living together □ married
□ separated □ divorced □ widowed
Date of marriage _____
How long did you know your spouse before marriage? _____
Were you (or your spouse) pregnant when you got married? _____
Any previous marriages? □ Yes □ No
If yes, please describe:_____
Previous spouse name: _____
Date of Marriage _____
Date of Divorce _____
Any children? □ Yes □ No Who has custody? _____
Has your spouse been previously married? □ Yes □ No
Date of Marriage _____
Date of Divorce _____
Any children? □ Yes □ No Who has custody? _____
Are you seeking therapy/counseling because of problems in your marriage? □ Yes □ No
If yes, please explain: _____
_____
_____

SEXUAL HISTORY
When and how did you first learn about sex? _____
_____
At what age was your first sexual experience? _____ was this: □ positive □ negative
What were your parent's attitudes toward sex? (e.g. was there sex instruction or discussion in your home?) _____
_____
Is your sex life satisfactory? □ Yes □ No
Are you able to experience arousal? □ Yes □ No
Are you able to experience climax? □ Yes □ No
Do you have any problems in obtaining sexual satisfaction, or sharing it with a partner? □ Yes □ No
If yes, please describe: _____
Are gender or sexual orientation concerns part of your reason for seeking treatment? □ Yes □ No
If yes, please describe: _____
_____
Do you use birth control? □ Yes □ No If yes, what kind? _____
Have your ever been sexually assaulted, harassed, raped or sexually abused? □ Yes □ No
If yes, please explain: _____
_____
Have you ever been physically abused? □ Yes □ No
If yes, please explain: _____
_____
Have you ever been told to promise never to talk about your physical abuse? □ Yes □ No

MENTAL HEALTH HISTORY:
Have you ever had psychotherapy and/or counseling? □ Yes □ No
If yes, when: _____
Where: _____
How long? _____
With Whom? _____
Reason: _____
Was it helpful? □ Yes □ No
What was helpful (describe): _____
_____
Anything you didn't like about the experience? _____

Briefly describe your basic personality: _____
_____
_____
What do other people think of you? _____
What are your strengths? _____
What are your vulnerabilities? _____
Have you ever taken medication for emotional problems in the past? □ Yes □ No
If yes, please list and indicate whether or not you found them helpful: _____
_____
_____
_____
Have you ever been hospitalized for emotional reasons or substance abuse? □ Yes □ No
If yes, please indicate the following:
Date Where (name town & facility) How long? Reason?
_____
_____
_____
_____
Have you ever thought of harming yourself? □ Yes □ No
Do you cut or self-mutilate? □ Yes □ No If yes, please explain: _____
Have you ever attempted suicide? □ Yes □ No
If yes, please give the date(s) and attempt method(s): _____
_____
Have any family members attempted suicide? □ Yes □ No
If yes, give date(s), how, and name relationship:
_____
_____
Have any family members (parents, grandparents, sisters/brothers, children, aunts, uncles, cousins) been hospitalized for emotional reasons, had alcohol problems, committed suicide, been diagnosed with mental illness or had severe mood swings? □ Yes □ No
If yes, please list their relationship to you and what the problem was:
Relationship *Problem*
_____
_____
_____
_____
_____

Please rate yourself on a scale of 1 to 10:
('10' signifying you excel in, '5' signifying you are average in, and '1' signifying you have great difficulty with):
_____ I can deal constructively with reality
_____ I can adapt to change
_____ I am free from symptoms that are produced by tensions and anxieties
_____ I find more satisfaction in giving than receiving
_____ I can relate to other people in a consistent manner with mutual satisfaction and helpfulness
_____ I direct my angry energies into creative and constructive outlets
_____ I have a capacity to love
Areas of your life where you exhibit generosity or are successful:
_____
_____
Do you have coping skills that you use when you are stressed or upset? □ Yes □ No
If yes, please describe your strategies and how helpful they are:
_____
_____
_____

SUBSTANCE USE

Do you enjoy a drink now and then? □ Yes □ No
How much alcohol do you drink?

Type of Drink	*Frequency of Use*	*Date of Last Use*	*Age of First Use*
Wine			
Beer			
Hard Liquor			

Can you stop drinking without difficulty after 1 or 2 drinks? □ Yes □ No
Do you often drink more than you intend? □ Yes □ No
Do you routinely drink in certain situations or certain times? □ Yes □ No
In what situations are you most likely to drink?

_____
_____

Do you use any of the following (indicate if you have used previously):

Substance:	*Amount Used*	*Frequency of Use*	*Date Last Used*	*Age Started Using*
Cocaine				
Marijuana/Hasish/Spice				
Barbiturates/Tranquilizers				
Amphetamines				
Hallucinogens				
Over the Counter/Prescription Pills				
Crystal Methamphetamine				
Inhalants				

What are your drug/alcohol preferences?_____
Do your spouse, parent(s) other relatives or friends ever worry or complain about your drinking or drug use? □ Yes □ No
Have you had any financial problems as a result of your substance use such as excessive debt, loss of income due to job loss, or spending cost of living money (i.e., rent money) on drug use? □ Yes □ No
If yes, please describe: _____
Have you had any problems on the job as a result of your substance use such as lateness, absenteeism, arguments or problems with coworkers and bosses, poor productivity, difficulty concentrating, loss of employment, suspension or warnings on the job? □ Yes □ No
If yes, please describe: _____
When under the influence of a substance, are you more aggressive, engage in dangerous behavior such as driving under the influence, operating equipment or caring for children? □ Yes □ No
If yes, please describe: _____
_____
_____

Have you had any family problems as a result of your substance use such as conflict with family members, negligence in caring for dependents or irresponsible behavior toward other family members. □ Yes □ No
If yes, please describe: _____
_____

Have you lost interest in socializing with others who do not use substances or in activities which do not include substance use? □ Yes □ No
If yes, please describe: _____
How many of your friends use alcohol more than once per week?
□ less than 20% □ less than 50% □ 50% or more
How many of your friends use other substances such as marijuana, cocaine, heroin, etc.?
□ less than 20% □ more than 20%
Have you had any medical problems as a result of your substance use, such as, frequent hangovers, memory loss, seizures, hallucinations, breathing problems, overdose or symptoms of withdrawal when not using? □ Yes □ No
If yes, please describe: _____

Have you had any prior treatment for substance abuse? □ Yes □ No
If yes, please describe: _____
_____
Have you ever attended A.A., N.A., C.A. or other 12-step programs? □ Yes □ No
If yes, please describe the circumstances, how often you attend(ed) and your thoughts about the process:
_____
_____
Do you have a sponsor? □ Yes □ No
Are you using your sponsor? □ Yes □ No
Is there a history of substance use in your family? □ Yes □ No
If so, please indicate which members have been or are affected?
_____
_____
_____
What happens to you when you use your substance of choice and how does it affect you attitude, mood, and behavior change?
Drug of Choice: *Attitude, Mood, or Behavior Change*
_____
_____
_____
_____
_____
_____

Have you tried to control your use by doing any of the following: *(check if appropriate)*
Cutting back on how much or how quickly you use? □ Yes □ No
Changing the time of day or situation in which you use? □ Yes □ No
Trying to substitute other substances to try and cut back on use? □ Yes □ No
Using other substances or drugs to control or take away uncomfortable feelings after using your primary substance? □ Yes □ No
Attempting to abstain temporarily? □ Yes □ No
If you check any of the above, how have attempts to control your use worked?
_____
_____
_____
Have you ever tried to stop using, if yes, what happened?
_____
_____

After a period of using either alcohol or other substances, do you experience any of the following?
(Check those that apply)
□ Nausea, vomiting □ dehydration
□ Diarrhea □ muscle spasm
□ chills □ tremors
□ increased anxiety or agitation □ auditory hallucinations
□ depression/feelings of crashing □ heart racing
□ Abdominal cramps or pain □ powerful cravings
□ increased body temp or perspiration □ weakness
□ Headaches □ relief from any of the above symptoms after drinking more alcohol, taking more of same drug, or using some other mood altering substance to alleviate uncomfortable symptoms
Have you had any legal problems as a result of your substance use such as: DWI, disorderly conduct, assault, theft, possession, or dealing of substances. □ Yes □ No
If yes, please describe:
_____
_____

WORLD VIEW/PHILOSOPHY/RELIGIOUS/SPIRITUAL HISTORY

Please briefly describe your spiritual beliefs, life philosophy, political or world view:
_____
_____
Religious/spiritual background of spouse/partner: _____
How frequently do you attend religious services? _____
Where did you attend in childhood? _____
Have either yourself or your spouse changed your religious or spiritual practice? □ Yes □ No
If yes, please explain:
_____
Is philosophy, politics, religious or philosophical belief a source of conflict in your relationship(s)?
□ Yes □ No If yes, please explain: _____
_____
Parents' religious practice:
Father _____
Mother _____
Do you hold membership in any church, synagogue, or other religious group? □ Yes □ No
Name of your spiritual or religious leader: _____
Name of your religious, spiritual or philosophical group: _____
Have you experienced any religious or philosophical conversion? □ Yes □ No
Are your beliefs a source of comfort and/or distress? □ Yes □ No If yes, please explain:
_____
_____
_____

Does your world view, philosophy, political or spiritual belief affect your life choices? □ Yes □ No
If yes, please describe:
_____
_____
_____

Your signature_____Date _____