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INFORMATION FORM

The purpose of this questionnaire is to obtain information about your present difficulties.

General Information:

Name: _____ Date of Birth:_____

Occupation:_____

Members of Household: Spouse/Significant Other's Name:

Name: _____ Age: _____

Occupation:_____

Children/ Other family members living in your home:

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Name:_____ Age: _____ Relationship:_____

Date(s) of Marriage (s)/Separation/Divorce/Significant Relationships:

_____

If separated or divorced with children, please describe your children's relationship with their other parent:_____
_____
_____

Current Difficulties:

Please state in your own words the difficulties that you or you and your spouse/partner are experiencing:

_____

_____

_____

_____

_____

_____

When did these problems begin?_____

Are there any significant events occurred at that time, or since then, which may relate to your problems?

_____

_____

_____

_____

_____

Please circle all that apply to any members of your family (place family member's initials next to the symptom):

Suicide attempts _____	Can't keep a job _____	Takes drugs_____
Impulsive _____	Compulsive _____	Insomnia _____
Drinks too much_____	Smokes _____	Takes risks _____
Works too hard_____	Withdraws _____	Sexual problems _____
Procrastination_____	Nervous tics_____	Eating problems _____
Aggressive behavior_____	Concentration problems _____	Out of control_____
Business/Financial problems_____	Sleep problems_____	Crying _____
Fears/Phobias_____	Temper Outbursts_____	Disorganized thinking _____

Any concerns regarding:

Domestic Violence

_____

_____

_____

Physical, Psychological and/or Sexual Abuse (current or past)

_____

_____

_____

What are your goals for therapy?

_____

_____

_____

_____

_____

Have you or your spouse/significant other ever been in therapy before or received any prior professional assistance for problems?

_____

_____

_____

Have you or your spouse ever been diagnosed with any psychological problems, taken psychiatric medications, been hospitalized psychiatrically, or had difficulty with the law?

_____

_____

_____

_____

_____

_____

Physical Health:

Describe any significant medical problems that you may have (past/present):

_____

_____

_____

_____

_____

_____

What medications (name, dosage, dates of usage), prescription or otherwise, do you take?

Name:_____ Dosage:_____

Name:_____ Dosage:_____

Name:_____ Dosage:_____

Name:_____ Dosage:_____

Religion

What would you like me to know about your participation in religious activities?

_____

_____

_____

_____

_____

Do you want your religious beliefs incorporated into the therapy process?

_____

_____

_____

_____

Cultural

What cultural/ethnic group do you include yourself in? How do you want it incorporated into the therapy process?

_____

_____

_____

Recreation

What do you and/or your child/family do for fun (e.g. hobbies, interests, activities)?

_____

_____

_____

_____

_____

Strengths:
Please describe your and your spouse/significant other's strengths:

_____

_____

_____

_____

_____