Questionnaire: A Comprehensive Understanding of your Life Experience and Background

PLEASE COMPLETELY FILL OUT THE FOLLOWING PAGES

Date: _____ Name: _____

Address:_____
_____
_____
_____

Telephone Numbers
(Day) _____
(Evenings) _____
Where can a message be left? _____

DOB _____ Age _____ Occupation _____

Place of Birth _____

Immigrated _____Status_____

By whom were you referred? _____

Where do you reside? __ House __ Apartment __ with family __ Hotel __ Other __

With whom do you reside? Brief description of these relationships.

Significant relationship status (check one) – state how long

__ single __ separated __committed relationship
__ engaged __ divorced __ widowed
__ married __ remarried

If married, partner's name, age, occupation? _____

Give brief details of previous relationships_____

Children

_____ How many _____

_____ (Y/N) Any significant problems with any of these children?_____ _____

Names, ages, gender

_____ _____

_____

Any history of abuse (emotional, physical, sexual) in current of previous relationships:

_____

_____

_____

Role of religion and/or spirituality in your life:

a. In childhood _____
b. As an adult _____

Clinical

a. State in your words the nature of you main problems and how long they have been present:

b. Give a brief history and development of your complaints (from onset to present):

c. On the scale below please check the severity of your problem(s):

__ mildly upsetting
__ moderately severe
__ very severe
__ extremely severe
__ totally incapacitating

d. Whom have you previously consulted about your present problem(s)?

e. Are you taking any medications? If "yes", what, how much, and with what results?

_____

_____

Personal Data

a. Mother's condition during pregnancy (as far as you know): _____
b. Check any of the following that applied to you during your childhood:

__ night terrors
__ thumb sucking
__ fears
__ bedwetting
__ nail biting
__ happy childhood
__ sleepwalking
__ stammering
__ unhappy childhood
__ any others _____

c. Health during childhood? List illnesses_____

_____

Health during adolescence? List illnesses _____

_____

d. What is your height? _____ Your weight? _____

e. Any drastic changes with your weight? _____

f. Any surgical operations? (please list them and give the age at the time_____

_____

g. Any accidents:_____

_____

h. Underline any of the following that apply to you:

- Headaches
- Palpitations
- Bowel Disturbances
- Anger
- Nightmares
- Feel tense
- Depressed
- Unable to relax
- Don't like weekends or vacations
- Can't make friends
- Can't keep a job
- Financial problems
- Excessive sweating
- Dizziness
- Stomach trouble
- Fatigue
- Take sedatives
- Feel panicky
- Conflict
- Suicidal ideas
- Sexual problems
- Overambitious
- Inferiority feelings
- Memory problems
- Lonely
- Use aspirin or painkillers often
- Fainting spells
- Anxiety
- No appetite
- Feel cold a lot
- Insomnia
- Alcoholism
- Tremors
- Take drugs
- Allergies
- Shy with people
- Can't make decisions
- Home conditions bad
- Unable to have a good time
- Concentration difficulties

Please list additional problems or difficulties here.

i. Any family history of drug and/or alcohol use? Who?_____

j. Circle any of the following words which apply to you:

Worthless	Incompetent	Horrible thoughts
Useless	Naïve	Hostile
A "nobody"	"Can't do anything right"	Full of hate
"Life is empty"	Guilty	Anxious
Inadequate	Evil	Agitated
Stupid	Morally wrong	Cowardly

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Unassertive	Lonely	Full of regrets
Panicky	Unloved	Worthwhile
Aggressive	Misunderstood	Sympathetic
Ugly	Bored	Intelligent
Deformed	Restless	Attractive
Unattractive	Confused	Confident
Repulsive	Unconfident	Considerate
Depressed	In conflict	

K. List your five main fears:

1) _____

2) _____

3) _____

4) _____

5) _____

l. Present interests, hobbies and activities _____

m. How is most of your free time occupied? _____

n. Do you belong to any clubs organizations?_____

o. Were you ever bullied or severely teased? _____

p. Do you make friends easily? _____

q. Do you keep your friends? _____

Educational history

a. What is the last grade of school that you completed? _____

b. Scholastic abilities: strengths and weaknesses?_____

c. Describe your school experiences. _____

_____

d. Were there any problems with truancy, suspensions, special education, vocational training, etc.?

_____

_____

Occupational Data

a. What sort of work are you doing now?

b. List previous jobs.

c. Does your present work satisfy you? (If not, in what ways are you dissatisfied?)

d. Is your income substantial enough to meet your cost of living?

e. Ambitions/Goals: Past_____

_____

Present_____

_____

_____

If on a leave of absence or disability, will you return to your present job?

_____

Sex information (please complete only if relevant to you course of treatment)

a. Parental attitudes toward sex (e.g. was there sex instruction or discussion in the home?)

b. When and how did you derive your first knowledge of sex?

c. When did you first become aware of your own sexual impulses?

d. Did you ever experience anxieties or guilt feelings arising out of sex or masturbation? If "yes" please explain.

e. Pleas list any relevant details regarding your first or subsequent sexual experience.

f. Is your present sex life satisfactory? (if not, please explain).

g. Are you sexually inhibited in any way?

Menstrual History (please fill out only if necessary for treatment

a. Age of first period?_____
b. Were you informed or did it come as a shock?
c. Are you regular? _____
d. Duration _____
e. Do you have pain? _____
f. Date of last period _____
g. Do your periods affect your moods?_____

_____

Marital History

a. How long did you know your marriage partner before engagement?

b. How long have you been married

c. How long have you been in a common-law relationship

d. Partner's age & Occupation

e. Describe the personality of your partner (in your own words)

f. In what areas is there compatibility?

g. In what areas is there incompatibility?

h. How do you get along with your in-laws? (This includes brothers and sister's-in-law)

i. Any history of miscarriages or abortions?

j. Comments about any previous marriage(s) and brief details.

Family Data

a. Father
Living or deceased?
If deceased, your age at the time of his death.
Cause of death.

If alive, father's present age.
Occupation:
Health:

b. Mother
Living or deceased?
If deceased, your age at the time of his death.
Cause of death.

If alive, mother's present age.
Occupation:
Health:

c. Siblings
Numbers of brothers:
Ages
Numbers of sisters
Ages

d. Relationship(s) with brothers and sisters:

Past _____

_____

Present _____

_____

e. Give a description of your father's personality and his attitude toward you (past and present)

f. Give a description of your mother's personality and her attitude toward you (past and present)

g. In what ways were you punished by your parents as a child?

h. Give impressions of your home atmosphere (i.e. the home in which you grew up, including compatibility between parents and between parents and children).

i. Were you able to confide in your parents?

j. Did you parents understand you?

k. Basically, did you feel loved and respected by your parents?

l. If you have a step-parent, give your age when your parent remarried:

m. Describe your religious training:

n. If you were not raised by your parents, who did raise you, and between what years?

o. Has anyone (parents, relative, friends) ever interfered in your marriage, occupation etc.?

p. Who are the most important people in your life?

q. Does any member of your family suffer from alcoholism, epilepsy, or anything which can be considered a "mental disorder"?

r. Are there any other members of the family about whom information regarding illness, etc., is relevant?

s. Recount any fearful or distressing experiences not previously mentioned?

General

a. What do you expect to accomplish from therapy, and how long do you expect therapy to last?

b. List any situations which make you feel calm or relaxed

c. Have you ever lost control (e.g. temper or crying or aggression)? If so, please describe.

d. Please add any information brought up by this questionnaire that may aid your therapist in understanding and helping you.

Self-Description (Please complete the following):

I am a person who

All my life

Every since I was a child

One of the things I feel proud of is

It is hard for me to admit

One of the things I can't forgive is

One of the things I feel guilty about is

If I didn't have to worry about my image

On of the ways people hurt me is

Mother was always

What I needed from my mother and didn't get was

Father was always

What I need from my father and didn't get was

If I weren't afraid to by myself, I might

On of the things I am angry about is

What I need and have never received from a woman or man is

The bad thing about growing up is

One of the ways I could help myself but do not is

Final thoughts

a. What is there about your present behavior that you would like to change?

b. What feelings do you wish to alter (e.g. increase or decrease)?

c. What sensation are especially:

1. pleasant for you?

2. unpleasant for you?

d. Describe a very pleasant image of fantasy:

e. Describe a very unpleasant image of fantasy.

f. What do you consider your most irrational thought or idea?

g. Describe any interpersonal relationship that gives you:

1. joy
2. grief

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

With the remaining space and blank side of these pages, give a brief description of you by the following people:

a. yourself
b. your partner
c. your best friend
d. someone who dislikes you