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# PSYCHOLOGICAL & SOCIAL BACKGROUND SUMMARY

*Please provide the following information for our records. Leave blank any question you would rather not answer at present. Information you provide here is held to the same standards of confidentiality as our therapy.*

*Please bring this form to your first session and allow yourself 30 minutes prior to your appointment to complete the form in the office. Thank you.*

Name: ______________________________________________________________
(Last) (First) (Middle Initial)

Birth Date: ______ /______ /______ Age: ________ Date: ________

Marital Status: (please circle one)

Never Married Married Separated Divorced Widowed

Local Address: ____________________________________________________________
(Street and Number)

______________________________________________________________________
(City) (State) (Zip)

Home Phone: ( ) - May we leave a message? YES / NO

Work Phone: ( ) - May we leave a message? YES / NO

Cell/Other Phone: ( ) - May we leave a message? YES / NO

E-mail: ________________________________________ May we email you? YES / NO
(Please be aware that email might not be confidential.)

Biological Mother: ____________________________________________________

Biological Father: ____________________________________________________

Siblings and Ages: ______________________________________ _______

______________________________________ _______

______________________________________ _______

Are you currently in a couple relationship (marriage, dating, etc.)? YES / NO

If yes, how long have you been in this relationship? _______

On a scale of 1-10, low to high, rate the quality of your current relationship: ________

If applicable, list name(s) and age(s) of:

Spouse: ____________________________________________ ________

Children: ____________________________________________ ________

____________________________________________ ________

____________________________________________ ________

**OCCUPATIONAL INFORMATION**:

Are you currently employed? YES / NO

If yes, who is your current employer?

______________________________________________________________________________

Describe what type of work you do:

______________________________________________________________________________

How many hours per day and per week do you work?

______________________________________________________________________________

On a scale of 1 to 10, with 1 being very unhappy to and 10 very happy, how would you rate how much you enjoy and are happy with your work? _________

Please list any work-related stressors, if any:

______________________________________________________________________________

**PRESENTING ISSUE**

What is the problem for which you seek counseling?

______________________________________________________________________________

______________________________________________________________________________

What have you done about this problem that has worked? How has it worked?

______________________________________________________________________________

______________________________________________________________________________

What have you done that has not worked? How do you know?

______________________________________________________________________________

______________________________________________________________________

What emotions do you feel when you think about this problem?

______________________________________________________________________

On a scale of 1 to 10, low to high, how intense are these emotions when you think about the problem? ________

What other persons, if any, are affected by this problem?

______________________________________________________________________

**STRESS ISSUES**

In the last year, have you experienced any significant life changes? If yes, please describe:

______________________________________________________________________

______________________________________________________________________

What level of stress do you feel you are experiencing at this time? (Check one.)

[ ] Minimal [ ] Average [ ] Considerable [ ] Unbearable

What are the major factors of your stress? (Check all that apply.)

[ ] Financial [ ] Marital [ ] Health [ ] Unfulfilled expectations

[ ] Spiritual [ ] Career [ ] Family [ ] Children

[ ] Body image [ ] Other ______________________________________

How does your stress manifest itself (use back, if need more space)?

______________________________________________________________________

______________________________________________________________________

How do you cope with stress?

______________________________________________________________________

______________________________________________________________________

How would you **prefer** to cope with stress?

______________________________________________________________________

______________________________________________________________________

**PHYSICAL CARE AND LIFESTYLE**

How do you rate your physical health at present? (please circle one)

Poor Unsatisfactory Satisfactory Good Very good Excellent

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.):

______________________________________________________________________

______________________________________________________________________

Are you having any problems with your sleep habits? YES / NO

If yes, circle all that apply:

Sleeping too little Sleeping too much Poor quality sleep

Disturbing dreams Other __________________________

How many hours, on average, do you sleep at night? __________

Do you nap during the day, and if so, how many hours? __________

What time do you go to sleep at night? __________

Do you awaken feeling rested? ___________

Describe any other regular sleep disturbances, if any, and state how often:

______________________________________________________________________

______________________________________________________________________

Are you having any difficulty with appetite or eating habits? YES / NO

If yes, circle all that apply: Eating less Eating more Binging Restricting

Have you experienced significant weight change in the last 2 months? YES / NO

Describe weight changes, if any:

______________________________________________________________________

______________________________________________________________________

Do you smoke? YES / NO

If yes, how many cigarettes per day? ______________

If no, does anyone in your household smoke YES / NO

If yes, how many family members smoke: ______________
Do you drink alcohol? YES / NO

If yes, how many drinks on average per day in past year? ____________________

At most, how many drinks have you had in one night in the past year? __________

Do you use any recreational drugs? YES / NO

If yes, how often and what type? ______________________________________________

How many main meals a day do you eat? _______ Times of day? _______

How many snacks a day do you eat? _______ Times of day? _______

In your opinion, do you regularly keep a healthy eating lifestyle? YES / NO

Describe the reasons you think it is or isn't healthy:

_____________________________________________________________________________

_____________________________________________________________________________

Indicate how often you eat or use the following (1 – rarely; 2 – regularly; 3 – often)

[ ] Luncheon meats [ ] Candy [ ] Margarine [ ] Processed foods

[ ] Cigarettes [ ] Microwave [ ] Fried foods [ ] Artificial sweeteners

[ ] Aluminum pans [ ] Desserts [ ] Cooking wine [ ] Over the counter drugs

Indicate how many cups or glasses you drink per day of the following:

[ ] Coffee [ ] Tea [ ] Herbal tea [ ] Soft drink [ ] Diet soft drink

[ ] Milk [ ] Water [ ] Wine [ ] Beer [ ] Other alcohol

How many times per week do you exercise? ___________

Approximately how long each time? ___________

If applicable, what do you do for exercise?

_____________________________________________________________________________

_____________________________________________________________________________

How many times per week do you **want** to exercise, and for how long?

_____________________________________________________________________________

How many hours, on average, per day do you spend:

[ ] Driving [ ] Watching TV [ ] Reading [ ] In front of computer

What are your interests and hobbies, present and past?

_____________________________________________________________________________

______________________________________________________________________

Do you vacation regularly?  YES   / NO

When was your last vacation, where did you go, and for how long?

______________________________________________________________________

______________________________________________________________________

**RELIGIOUS/SPIRITUAL**

Do you actively participate in a religious or spiritual discipline?     YES  /   NO

If no, do you consider yourself to be spiritual? YES  /   NO

If yes or no, please elaborate:

______________________________________________________________________

______________________________________________________________________

Do you meditate, have a quiet time or pray regularly?      YES  /   NO

**PREVIOUS OR OTHER TREATMENT**

Are you currently receiving professional counseling or therapy elsewhere?   YES  /  NO

Are you currently receiving psychiatric services?   YES  /  NO

If yes to either above, please list type of service, dates, problem, name and address of provider (if you need more space, use the back):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Are you currently taking prescribed psychiatric medication (i.e., antidepressants)?  YES /  NO

If yes, please list medication and dosage:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Have you received psychological services in the past?     YES / NO

If yes, please list type of service, dates, problem, name and address of provider (if you need

more space, use the back):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

List any past medications (no longer taking), dosage and the reason each was prescribed:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Are you currently being treated for medical problems? In the past? YES / NO

If yes to either above, please list problem, dates, medication/dosage, name and address of provider (if you need more space, use the back):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**DEVELOPMENTAL HISTORY**

Date and place of birth: ______________________________________________

Describe pertinent information during pregnancy, birth, and early development:

________________________________________________________________________

________________________________________________________________________

Describe any pertinent academic issues and educational experiences:

________________________________________________________________________

**Have you experienced any of the following in the past or present (please circle):**

| | | |
|---|---|---|
| Extreme depressed mood | YES / NO | Past / Currently |
| Wild Mood Swings | YES / NO | Past / Currently |
| Rapid Speech | YES / NO | Past / Currently |
| Extreme Anxiety | YES / NO | Past / Currently |
| Panic Attacks | YES / NO | Past / Currently |
| Phobias | YES / NO | Past / Currently |
| Sleep Disturbances | YES / NO | Past / Currently |
| Hallucinations | YES / NO | Past / Currently |
| Alcohol/Substance Abuse | YES / NO | Past / Currently |
| Frequent Body Complaints | YES / NO | Past / Currently |
| Eating Disorder | YES / NO | Past / Currently |
| Body Image Problems | YES / NO | Past / Currently |
| Repetitive Thoughts (e.g., Obsessions) | YES / NO | Past / Currently |
| Repetitive Behaviors (e.g., Checking, Hand-Washing) | YES / NO | Past / Currently |
| Homicidal Thoughts | YES / NO | Past / Currently |

Have you had suicidal thoughts in the last two months? (Please circle one)

Frequently    Sometimes    Rarely    Never

Have you had suicidal thoughts in the past? (Please circle one)

Frequently    Sometimes    Rarely    Never

Have you made at suicide attempts in the past?

If yes, list dates: ________________________________________

**PREVIOUS MARRIAGES**

Have you been previously married? YES / NO

If yes, provide the following information, for each:

| Years Married | Total Years Together | Years Divorced | Reason for Divorce |
|---|---|---|---|
| ________ | ________ | ________ | ________________________________ |
| ________ | ________ | ________ | ________________________________ |
| ________ | ________ | ________ | ________________________________ |

**FAMILY MENTAL HEALTH AND TREATMENT HISTORY:**

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle yes or no to each, and list family member, e.g., Sibling, Parent, Uncle, etc.):

| **Difficulty** | | **Family Member(s) Affected:** |
|---|---|---|
| Depression | YES / NO | |
| Bipolar Disorder | YES / NO | |
| Anxiety Disorders | YES / NO | |
| Panic Attacks | YES / NO | |
| Schizophrenia | YES / NO | |
| Alcohol/Substance Abuse | YES / NO | |
| Eating Disorders | YES / NO | |
| Learning Disabilities | YES / NO | |
| Trauma History | YES / NO | |
| Suicide Attempts | YES / NO | |

Describe family history of psychological treatment, if any:

_______________________________________________________________________________

_______________________________________________________________________________

Describe family history of drug and/or alcohol dependency, if any:

_______________________________________________________________________________

_______________________________________________________________________________

Describe other pertinent factors in family history, i.e., abuse, trauma:

___________________________________________________________________________

___________________________________________________________________________

**COUPLE RELATIONSHIP**

Briefly describe relationship with spouse, or significant other, if applicable:

_______________________________________________________________________________

_______________________________________________________________________________

Briefly describe your relationship with parents and siblings, if applicable:

_______________________________________________________________________________

_______________________________________________________________________________

Briefly describe your relationship with your children, if applicable:

______________________________________________________________

______________________________________________________________

______________________________________________________________

Describe other information regarding your home life that may be relevant to restoring your mental, emotional, and physical health and wholeness:

______________________________________________________________

______________________________________________________________

______________________________________________________________

**OTHER INFORMATION**

What do you consider to be your strengths?

______________________________________________________________

What do you like most about yourself?

______________________________________________________________

What are effective you've learned to cope with challenges and stress?

______________________________________________________________

What are your goals for therapy?

______________________________________________________________

______________________________________________________________

**FAMILY THERAPY**

List any family members over the age of 12 you may want to include in family therapy in the future:

______________________________________________________________

______________________________________________________________

Have you considered, or are you willing to engage in couple therapy, if necessary (and applicable):

YES / NO / MAYBE

If YES, is your spouse or significant other, in your opinion, willing to engage in couple therapy, if necessary:

YES / NO / MAYBE