Information

Name: (Last, First, M I): _____

Birthday	_____	Rank:	_____
Age		Email Contact	Privacy not guaranteed. Yes/no
Home address:	_____	Text Contact	Privacy not guaranteed. Yes/no
Home Phone:	_____ Leave message? Yes/No	Cell:	_____ Leave message? Yes/No
Work Phone:	_____ Leave message? Yes/No	Unit:	_____

Main Problems: Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1 2 3 4 5 6 7 8 9 10

Not a problem Mild Problem Moderate Problem Severe Problem Couldn't be worse

	Rating	How long a concern now?	Problem before/When?
a.			
b.			
c.			

2. Please briefly describe what motivated you to seek therapy ***at this time*** as opposed to earlier or later.

3. Have you ever been treated by a mental health provider before? Yes/No

4. If yes,

When	Where	Reason:

5. What, if anything, seemed to help? _____

Military History

a. Branch of Service (Self or Sponsor):

USA		USAF		USN		USMC		USCO		CIV		Family Member	

b. MOS _____ Job Title: _____

c. Duty Status:

Regular Active Duty		Retired		Reserve on AD		National Guard on AD	

d. Time in Service: Total _____ Active Duty _____ In Current Unit: _____

Drilling Reserve/NG _____ IRR _____ "Good" Years Reserve Retirement _____

e. Dates of Service: _____ to _____

f. Have you been deployed? Yes/No

g.. If yes,

Information

When	Where

g. Are you deploying soon? Yes/No

i. Please list any awards you have received:

Award	Date(s)

Early History

1. Where you were born, and who raised you? _____
2. Were you adopted? Yes/No. If yes, at what age? _____
3. How many siblings? Biological Sisters ____ Half Sisters _____ Step Sisters ____
   Brothers ____ Brothers _____ Brothers ____

Family Medical History:

1. Have your parents, grandparents or siblings had problems with alcohol ____ tobacco ____ drugs ____
   If yes, who? _____
2. Have your parents, grandparents, or siblings ever seen a mental health professional, including a psychiatrist? ____
   If yes, who and what was the problem and/or diagnosis? _____
3. Are there any medical conditions that run in your family? Please list.

Relationship	Name	Age	Living	Deceased (Year)	Living Yes	w/ you No
Mother						
Father						
Spouse						
Children						
Others (sibs, grandparents, extended family)						

4. What was it like in your childhood home? Loving ____ Comfortable ____ Chaotic ____ Abusive____
5. Do you feel that you were an abuse victim? Yes/No If yes: Physical ___ Emotional ____ Sexual ____
6. Which best describes your family? Poor ____ Middle Class ____ Wealthy ____
7. In youth, which best describes you? Social _____ Loner _____

Information

8. What sports, hobbies, or leisure activities did you enjoy in your youth?

Cultural/Ethnic:

To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic issues? Yes/No

If yes, describe: _____

What ethnic background is your Mother _____Father _____

Maternal Grandmother _____ Grandfather _____

Paternal Grandmother _____ Grandfather _____

Are there special, unusual or traumatic circumstances that affected your development? Yes/No

If yes, please describe _____

Personal Medical History

1. Are you in any physical pain? Yes/No

If yes, on a scale of 0 (None) to 10 (Hurts the worst you can imagine), how much pain do you have? ____

If yes, where do you have the pain? _____

2. Please list any major or serious medical problems you have or have had. List the year you had the condition or that it started. Indicate whether it is resolved or ongoing.

Condition	Status

3. Please list any surgeries you have had and the year they occurred:

Surgery	Year

4. What medications (prescription and over-the-counter) and/or nutritional supplements do you take?

Medication	Dose

5. Do you have problems with:

Headaches		Indigestion		Diarrhea		Constipation		Shortness of breath	
Heart Palpitations		Frequent Urination		Body aches/pain		Menstrual Problems		Stomachache/ Nausea	

6. How would you rate your overall health: Excellent Good Fair Poor

7. In the last year, how many visits to the doctor? _____ Days sick from work/school? _____

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9. Have you ever passed out? ____Yes _____No When? _____

10. Have you ever blacked out? _____Yes _____No When? _____

11. Have you ever had a head injury?

12. Have you ever been knocked out or diagnosed with a concussion?

Current Symptom?	Yes	No	Current Symptom?	Yes	No
Boredom			Do you feel worthless?		
Found yourself somewhere without knowing how you got there?			Do you lose periods of time?		
Do certain thoughts occur over and over again outside of your control?			Do you sometimes feel unreal?		
Do thoughts or images enter your mind that you can't get rid of?			Do you sometimes feel very powerful and important?		
Found objects in your possession that you do not recognize?			As a child did you have: Stammering? a Learning Disorder?		
Do you have moments where objects or people look strange or misshapen?			As a child were you given an attention deficit/hyperactivity disorder diagnosis?		
Zone out for long spaces of time?			As a child did you have any serious illnesses?		
Do you have difficulty falling asleep?			As a child, were you ever hospitalized?		
Do you have nightmares? Average hours of sleep per Night: _____			Reach developmental milestones (walking, talking, toileting) Early? Late?		
Do you wake early or wake tired?			Do you or have you frequently gotten in physical fights?		

Have you ever cut, burned, scalded, or otherwise injured yourself? Yes. No

If so, when and how? _____

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	Never	Seldom	Sometimes	Often	Always
I feel life just isn't worth living.					
Life is so bad I feel like giving up.					
It would be better for everyone involved if I were to die.					
I just wish my life would end.					
I have no hope or plans for the future.					
I feel worthless.					
I really dislike myself.					

Have you ever attempted to end your life? Yes. No
When and how? _____
If you were to try to end your life, how would you do it?

Do you have the means to carry out the method you described? Yes. No

Please rate current level of hope:

0 5 10

Please rate current level of physical pain:

0 5 10

Please rate current level of emotional pain:

0 5 10

Reasons to live:

1.

2.

3.

4.

5.

Reasons to die:

1.

2.

3.

4.

5.

Information

Nutrition:

How many meals on average do you eat a day? _____ Would you say they are healthy meals? _____Yes _____No

Do you regularly include fruit?: ___Yes ____No Do you include vegetables daily? ____Yes _____No

How many cups of coffee a day? _____ How many cups of tea? _____ How many sodas? _____

How many glasses of beer? _____ daily _____ weekly How many glasses of wine? _____ daily _____weekly

How many shots of hard liquor? _____ daily _____weekly

Do you take vitamins or supplements? _____ Yes _____ No If yes, what are they? _____

Have you used any non-prescription medications or substances in the last month? _____Yes _____No

If yes, please list and note how often for each _____

_____

How many times in the last month have you gotten drunk to escape feelings or stressors? _____

How many times have you taken a drink in the morning just to get ready for the day? _____

Have you ever gotten into trouble because of alcohol or some other substance? _____Yes _____No

Spirituality:

Would you characterize yourself as religious? _____Yes _____No

What religion do you follow, if any? _____

How often do you practice your religion? _____

How important is your religion to you as a source of strength and comfort? Please rate.

0 5 10

Social:

Check how you generally get along with other people (check all that apply):

Affectionate	____	Follower	____	Shy/Withdrawn	____
Aggressive	____	Friendly	____	Submissive	____
Avoidant	____	Leader	____	Other (specify):	
Fight/argue often	____	Outgoing	____	_____	

How many people would you call if you needed comfort or support?_____

Who are they? _____

How many close friends would you count? _____

How many people do you believe really care about you? _____

Who are they? _____ Friends _____Spouse/Partner/Significant Other _____ Family

Sexual History:

My sex life is: Good _____ Fair _____ Poor _____ Abstinent _____

Are you experiencing any sexual concerns? Yes/No

Do you feel guilty about any past sexual experiences? Yes/No

What percentage of the time do you practice safe sex? _____

Information

My first sexual relationship was at age _____

Legal History

1. Have you ever been arrested? Yes/No
2. Do you currently have any legal difficulties/issues? Yes/No If yes, please describe:

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3. (*Military only*) Have you ever had any administrative action taken against you? Yes/No
4. If yes, please describe or list: _____

Marital Status (more than one answer may apply):

Single		Married		Living together	
		How long		(How long)	
Widowed		Separated		Divorced	
(How long)		(How long)		(How long)	
Annulment		Total Marriages			
(How long)					

If married, please answer the following:

Are you and your spouse both active duty? Yes/No. N/A

How long did you date your spouse before marriage? _____

Are you currently living with your spouse? Yes/No

Rate your satisfaction with your marriage on a scale of 1 to 7 (poor to excellent): _____

Are you having any current problems in your marriage? Yes/No

If yes, please explain: _____

If married more than once, please list dates of marriage, dates of divorce, and the reason the marriage ended:

Please give a rough estimate of how many hours per week you spend doing the following in a typical week:

Working in your primary job _____
Parenting/caretaking others _____
Doing household chores _____
TV, movies _____
Physical recreation/exercise _____
Hobbies _____
Social activities with others _____
Spiritual activities _____
Quiet, relaxing time _____

Information

Life long functioning:

	Best Time	Average Time	Worst Time
0-5			
6-12			
13-19			
20-29			
30-39			
40-49			
50-59			
60-69			
70+			

Please describe the best times in your life:

Please describe the worst times in your life:

Information

Leisure

What do you do for pleasure or fun? _____

Describe special areas of interest or hobbies.

Activity	How often now?	How often in the past?

Nicotine:

Do you smoke? _____ Yes _____No How much per day? _____

When did you start? _____ Have you ever tried to quit? _____

Legal:

Current:

Are involved in any active cases (traffic, civil, criminal, UCMJ)? Yes/No

If yes, please describe: _____

Past

Traffic violations Yes/No DWI, DUI, etc.: Yes/No

Academic:

Highest Education: High school ___ (GPA) Associate's Degree ____ (GPA) Bachelor's Degree ____ (GPA)
Major: _____ Major: _____
Master's Degree ____ (GPA) Vocational school _____
Major: _____

What are your strengths: _____

_____.

Liking for yourself (rate 0 to 10 with 0 meaning none and 10 meaning love). 0 1 2. 3. 4. 5. 6. 7. 8. 9. 10

Have you ever failed or been held back a grade? Yes/No If yes, when? _____

Were you ever in a "gifted" or Advanced Placement class or program? Yes/No If yes, when? _____

Did you ever receive special services or have you ever been on an IEP? Yes/No

Is English your primary language? Yes/No If no, what is your primary language? _____

Are you currently in school or taking classes? Yes/No If yes, are you having difficulty? Yes/No

How do you feel you learn most effectively?

Have you ever been diagnosed with a learning disorder? Yes/No If yes, what category? _____

Information

Treatment goals

In your own words, and in order of importance to you, please list 3 changes you would like to see in the next 6 months:

In your own words, and in order of importance to you, please list 3 ways you would like to see your life, relationships and/or you change in the next year.

Information

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

Aggression		Elevated Mood		Phobias/Fears	
Alcohol Abuse		Fatigue		Recurring thoughts	
Anger		Gambling		Sexual addiction	
Antisocial behavior		Hallucinations		Sexual difficulties	
Anxiety		Heart palpitations		Sick often	
Avoiding people		High blood pressure		Sleeping problems	
Chest pain		Hopelessness		Speech problems	
Cyber addiction		Impulsivity		Suicidal thoughts	
Depression		Irritability		Thought sdisorganized	
Disorientation		Judgment errors		Trembling	
Distractibility		Loneliness		Withdrawing	
Dizziness		Memory impairment		Worrying	
Drug abuse		Mood shifts		Other	
Eating problems		Panic attacks			

Briefly discuss how these symptoms impair your ability to function effectively in your job:

_____

_____

Briefly discuss how these symptoms impair your ability to function effectively in relationships:

_____

Self Assessment of Functioning:

Please rate from 1 to 10 how well you feel you are currently functioning in each of the 3 areas below as follows:

10 9 8 7 6 5 4 3 2 1

Excellent Mild difficulty Moderate difficulty Severe difficulty Barely functioning

1. General mood (depression, anxiety, etc.) _____
2. Social relationships _____
3. Daily work _____

By my signature below, I acknowledge that I consent to treatment. I understand that my participation in treatment is voluntary and that I may withdraw at any time.

_____ _____

Signature **Date**

_____ _____

Sharon Stewart, PsyD **Date**