CLINICAL QUESTIONNAIRE (FORM1)

This questionnaire is designed to supply your therapist with comprehensive information about your past history and present situation. By completing these questions as fully and accurately as you can, you will facilitate your clinical assessment and therapy program. Thank you.

1. *GENERAL INFORMATION*

Name_____ Date_____

Address_____ Sex_____

City, State, Zip Code_____ Age_____

Phone Number_____

Primary Care Physician (PCP)_____

Insurance_____

Marital Status (circle one) Single; Engaged; Married; Remarried; Living With; Separated; Divorced; Widowed

2. *CURRENT CLINICAL DATA*

(A) Describe the main problem(s) that led you to seek therapy at this time, including the duration of the problem (or set of problems):

(B) Briefly describe the history of this problem, or set of problems, including a list of stress factors which seem to be triggering and/or intensifying the problem now:

©) Circle the degree to which you have been experiencing each of the following Moods, Emotions and Feelings as a result of the problem(s) that led you to seek therapy:

	Not at All	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Angry	0	1	2	3
2. Panicky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10.Lonely	0	1	2	3
11.Resentful	0	1	2	3
12.Dependent	0	1	2	3
13.Confused	0	1	2	3
14.Guilty	0	1	2	3
15.Nervous	0	1	2	3
16.Listless	0	1	2	3
17.Hopeless	0	1	2	3
18.Tense	0	1	2	3
19.Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21.Terrified	0	1	2	3
22.Embarrassed	0	1	2	3
23.Elated	0	1	2	3
24.Abandoned	0	1	2	3
25.Agitated	0	1	2	3
26.Worried	0	1	2	3
27.Helpless	0	1	2	3
28.Grief	0	1	2	3

Other emotional reactions:_____
_____

Circle how often you have been bothered by each of the following Difficulties with Thinking since the problem(s) that led you to seek therapy began:

	Never	Occasionally	Often
1. Concentration difficulties	0	1	2
2. Difficulty remembering things	0	1	2
3. Your mind going “blank”	0	1	2
4. Difficulty making decisions	0	1	2
5. Difficulty making sound judgments	0	1	2
6. Distractible	0	1	2
7. Thoughts are racing	0	1	2
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2
9. Repetitive thought(s), image(s), or urge(s)	0	1	2
10. Suicidal thoughts	0	1	2
11. Thoughts of killing someone	0	1	2
12. Preoccupation with thoughts of death	0	1	2

Other problems with your thought processes:_____

_____

Circle how much you have been distressed or bothered by each of the following Physical Reactions since the onset of the problem(s) that led you to seek therapy:

	Not at all or Only a Minimal Degree	To a Moderate Degree	To a Very Strong Degree
1. Shortness of breath or smothering sensations	0	1	2
2. Nausea, diarrhea, or other abdominal stresses	0	1	2
3. Trouble swallowing or "lump in throat"	0	1	2
4. Muscle tension . Aches, or soreness	0	1	2
5. Flushes (not flashes) or chills	0	1	2
6. Dizziness or light- headed	0	1	2
7. Trouble falling or staying asleep	0	1	2
8. Sweating, or cold clammy hands	0	1	2
9. Fatigue or loss of energy	0	1	2
10. Decrease in appetite	0	1	2
11. Weight loss	0	1	2
12. Decreased need for sleep	0	1	2
13. Numbness or tingling sensations	0	1	2
14. Weepiness/Crying	0	1	2
15. Palpitations or accelerated heart rate	0	1	2
16. Headaches	0	1	2
17. Increase in appetite	0	1	2
18. Weight gain	0	1	2
19. Increased need for sleep	0	1	2
20.Chest pains or discomfort	0	1	2
21.Physical problems (ex., impaired physical functioning physical pain, etc)	0	1	2
22. Awakening earlier in the morning than you normally do	0	1	2

Other physical reactions:_____

_____

Circle the degree to which you have been experiencing each of the following additional reactions since the onset of the problem(s) that led you to seek therapy:

	Not at all	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feeling like you want or beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3

	Not at all	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (ex., hearing voices, seeing shadows or images, etc.)	0	1	2	3
14. Increased alcohol use	0	1	2	3
15. Use of "street" (non-prescription) drugs	0	1	2	3

Any other effects or reactions, stemming from your problem(s), not described above:_____

_____

(D) Family Functioning: Briefly describe how the problems you are having have been affecting your relationships with family members (ex., your relationship with your spouse or partner, with your children, and with other significant relatives):

(E) Social Functioning: Briefly describe how the problems you are having have been affecting your social functioning with non-family members (ex., your relationship with friends):

(F) Work/School Functioning: Briefly describe how the problems you are having have been affecting your work (ex., performance levels, relationships with co-workers) and, if relevant, at school, has been affected by your current problem(s):

(G) Do you currently drink alcohol and/or use any drugs? Yes_____ No_____

If yes, indicate:

(1) Specifically, which substance(s) you use:

(2) Frequency of use:

(3) Situation(s) in which use occurs:

Is your current use of alcohol and/or drugs causing or contributing to problems in any aspect of your functioning (relationships with others, functioning at work or school, etc.)?

Yes_____ No_____

If yes, describe the nature of the problem(s) stemming from your current use of alcohol and/or drugs:

3. *HISTORICAL CLINICAL DATA*

(A) Have you had any previous problems for which you feel a mental health professional should have been seen, or for which you actually did seek professional help? Yes_____ No_____

If yes, state the problem(s):

Did you receive professional help for these problems: Yes_____ No_____

If you were seen as an outpatient, indicate when and where you were seen and the name(s) of the professional(s) with whom you were in treatment:

(B) Have you ever used alcohol in the past? Yes_____ No_____

If you have used alcohol:

(1) Have you ever tried to cut down on your drinking? Yes_____ No_____
(2) Have you ever been annoyed at other's complaints about your drinking? Yes_____ No_____
(3) Have you ever felt guilty about your drinking? Yes_____ No_____
(4) Have you ever taken a morning "eye opener" drink? Yes_____ No_____

©) Have you ever used drugs in the past? Yes_____ No_____

(D) Did your previous alcohol and/or drug use cause or contribute to problems in any aspect of your school functioning (ex., relationships with others, functioning at work, functioning at school, physical health, etc.)?

Yes_____ No_____

If yes, state the problem(s) stemming from your substance use:

(E) If you have received professional help for substance abuse problems, indicate when and where you received treatment, and the name of your primary counselor or therapist:

(F) Is there any family history of alcohol or drug problems, and/or problems of a psychiatric nature?
Yes_____ No_____

If yes, describe the nature of these problems:

4. *ADDITIONAL CLINICAL DATA*

(A) Have you ever:

	Present	Past	Never
a. experienced domestic violence in your marital/couple relationship	_____	_____	_____
b. made a suicide attempt	_____	_____	_____
c. been involved in child abuse:			
as a victim/survivor	_____	_____	_____
as a perpetrator	_____	_____	_____
d. been involved in sexual abuse			
as a victim/survivor	_____	_____	_____
as a perpetrator			
e. had an eating disorder	_____	_____	_____
f. felt that something was wrong with your mind	_____	_____	_____
g. physically threatened another person	_____	_____	_____
h. assaulted or attempted to kill another person	_____	_____	_____
I. felt that your thoughts were so loud people could hear them	_____	_____	_____
j. had periods of time you can't account for	_____	_____	_____
k. believed others were conspiring against you	_____	_____	_____
l. had periods of severe depression	_____	_____	_____
m. had periods in which you felt extremely optimistic, full of energy, could get by on little or no sleep, and/or thought and talked very fast	_____	_____	_____
n. felt compelled to help other people	_____	_____	_____
o. felt compelled to isolate yourself	_____	_____	_____
p. felt compelled to act as a "clown"	_____	_____	_____
q. felt the need to receive punishment	_____	_____	_____

5. *FAMILY DATA*

(A) Father:

If alive his present age:_____
If deceased, your age and his age at the time of his death:_____
Cause of death:_____
Occupation:_____
How would you describe your father, and how did you get along with him?:

Mother:

If alive her present age:_____
If deceased, your age and her age at the time of her death:_____
Cause of death:_____
Occupation:_____
How would you describe your mother, and how did you get along with her?:

Brothers and Sisters:

Name	Age	How did/do you get along with hi/her?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(B) Were you adopted as a child? Yes_____ No_____

©) Were you diagnosed as hyperactive as a child? Yes_____ No_____

(D) Were your parents separated or divorced during your growing years? Yes_____ No_____

(E) Were either of your parents seriously physically ill and/or absent for long periods of time during your growing up years? Yes_____ No_____

(F) Briefly describe any experiences you had while growing up in your family of origin that you believe may have a bearing on your present problem(s):

6. *SOCIAL/EDUCATIONAL/EMPLOYMENT/LEGAL DATA*

(A) Briefly describe any aspects of your social history, other than in your family of origin, that you believe may have a bearing on your present problem(s):

(B) Indicate the highest level of formal education that you have attained:

©) Briefly describe any experiences relating to school that you think may have a bearing on your present problem(s):

(D) Indicate your current occupation:

(E) How many times have you changed jobs in the last 5 years?:

(F) Are you a combat veteran? Yes_____ No_____

If yes, which War(s):_____

(G) Have you had any problem(s) of a legal nature (including arrests)? Yes_____ No_____

If yes, briefly describe what this involved:

7. *MEDICAL DATA*

(A) If you have had any past or current medical illnesses, surgeries, or traumas, give a brief description of these, including when they occurred:

(B) List any current medications (including dosage) that you take:

©) Indicate any allergies that you may have:

(D) Date of your last physical:

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