

About You

1. What goals would you like us to work on in therapy? What would you like to see change in your life as a result of our work together?
2. What in your present life makes you happiest?
3. What from your past makes you happiest?
4. What in your present life troubles you most?
5. What in your past troubles you most?
6. What are your hobbies and/or leisure activities?
7. What do you like most and least about your job, including “stay at home” parenting?
 - a. Most?
 - b. Least?
8. If retired, what do you like least and most about being retired?
 - a. Most?
 - b. Least?
9. Have you been in therapy before? ____ Yes ____ No

If yes, when, for how long, and what for (diagnosis or life event)?

Was it helpful?
10. Have you been hospitalized before for a psychiatric condition?

If yes, when, for how long, and what for (diagnosis or life event)?

Was it helpful?
11. Please list any current medical conditions you have:
12. Please list any past medical conditions you've had:
13. Please list all medications you are presently on for medical and psychiatric conditions:
14. What psychiatric medications have you been on in the past?
15. Are you married, partnered, or have a significant other?

____ married ____ partnered ____ significant other

16. How satisfied are you with this relationship?

17. How many times have you been married before?

18. Do you have children? ____ yes ____ no

If yes, how many? _____ Ages and genders (please indicate whether biological, step, adopted, or special needs):

Are there things you would like me to know about them that would help our work together?

Did you experience any difficult births? ____ yes ____ no

19. Are you adopted? ____yes ____ no

20. Are your parents still alive? ____ yes ____ no

If yes, are there any things you would like me to know about them that would help our work together?

21. Are there any maternal or paternal relatives, alive or deceased, or siblings who have or had mental illness or substance abuse or dependence? ____yes ____ no

If yes, who are they and what was/is the condition?

22. What are your happiest memories from childhood?

23. Saddest memories from childhood?

24. How often did you move during childhood and were any of these moves difficult for you?

25. Did your parents divorce?

26. What were your biggest challenges or traumas growing up?

27. Did you experience any abuse as a child or adult?

____ physical ____ emotional ____ sexual ____ rape

28. How did your parents show you love?

29. Was or is there anyone in your life from whom feel you receive/d unconditional love? _____ yes ____ no

- If yes, who was this person or persons?
30. Have you experienced any significant losses during your lifetime and if so, what were they and what impact did they have on you?
31. How satisfied are you with your current friendships?
32. Do you consider religion or spirituality an important part of your life? ___ yes ___ no.
- If yes, please describe in what ways it is important to you:
33. How many glasses of caffeine do you drink per day (coffee, tea, soda)?
34. How much alcohol do you drink (wine, beer, hard liquor) on a typical:
- a. Weekday
 - b. Weekend
35. Do you use any recreational drugs, prescription or street? ___ yes ___ no
If yes, what are they, how often and how much do you use?
36. Do you have a criminal history? ___ yes ___ no
- If yes, when and for what?
37. Are you involved in litigation now? ___yes ___no
- If yes, for what?
38. Have you been involved in litigation in the past? ___ yes ___ no
- If yes, when and for what?
39. How often and what type of exercise do you do, if any?
40. What time do you typically go to bed and wake up?
41. Do you ever have a hard time getting to sleep ____, waking up during the night ____, or waking up early (between 3 and 6 a.m.) ___ ?
42. Do you take sleeping medications? ___ yes ___ no
43. How many hours of sleep do you typically get?

44. Do you nap during the day? ___ yes ___ no

If yes, for how long?

45. Do you smoke? ___ yes ___ no

If yes, how many cigarettes per day?

46. Please describe your nutritional patterns:

| | |
|------------------------------------|------------|
| How many times per week do you eat | Breakfast? |
| | Lunch? |
| | Dinner? |
| | Snacks? |

| | |
|--------------------------------|------------|
| What time do you typically eat | Breakfast? |
| | Lunch? |
| | Dinner? |
| | Snacks? |

| | |
|---|------------|
| What does a typical meal consist of for | Breakfast? |
| | Lunch? |
| | Dinner? |
| | Snacks? |

47. Is there any else you'd like me to know about you that would help our work together?