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CHECKLIST OF CONCERNS AND HISTORY FORM

Name:_____ Date: _____
Please mark any items that apply to you.

PROBLEM AREAS--CAREER, SCHOOL
___Career concerns, goals, and choices
___Unemployment
___Job stress
___School problems
___Learning problems
___Work performance issues such as procrastination
___Work life balance issues (workaholism/overworking)
___Difficulty maintaining employment

PROBLEM AREAS--RELATIONSHIPS
___Communication problems
___Dating issues
___Detachment or estrangement from others
___Divorce, separation
___Friendships
___Feeling physically unsafe with my partner
___Infidelity, affairs
___Interpersonal conflicts
___Parenting issues
___Sexual issues with partner
___Social problems
___Physical fights with relationship partner
___Physical fights with others
___Relationship conflict
___Other Relationship problems (specify:
_____)
___Withdrawal, isolating

PROBLEM AREAS--LIFE EVENTS
___Childhood issues (your own childhood)
___Financial or money troubles, debt, impulsive spending, low income
___Grieving, mourning, deaths, losses
___Legal matters, charges, suits
___Other (Please specify: _____)

PROBLEM AREAS--PHYSICAL WELL-BEING
___Headaches, neck or back pain (Please specify: _____)
___Health, illness, medical concerns, physical problems
___Menstrual problems, PMS
___Pains, chronic (Please specify: _____)
___Sexual functioning problem (e.g. erectile dysfunction, painful intercourse)

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PROBLEM AREAS--SELF
___Identity issues
___Sexual identity issues
___Suicidal ideas
___Thoughts that life may not be worth living
___Self-esteem problems

EMOTIONAL CONCERNS
___Alert for danger, even in safe locations
___Anger, hostility
___Distressing memories of the past
___Suspiciousness
___Anxiety, nervousness
___Agitated
___Fear of leaving my home
___Fear of specific locations, such as elevators or planes (Please specify: _____)
___Fear of specific situations, such as heights or snakes (Please specify:_____)
___Fear of social situations
___Fear of abandonment
___Obsessive thoughts
___Panic or anxiety attacks
___Feeling hyper or wound up
___Shyness
___Tension—can't relax
___Attention, concentration
___Confusion
___Distractibility
___Memory problems
___Loneliness
___Depression, low mood, sadness, crying
___More depressed in the morning, with mood better later in the day
___More depressed in the winter, mood better in the summer
___Emptiness feelings
___Failure feelings
___Fatigue, tiredness, low energy
___Guilt
___Inferiority feelings
___Motivation problems
___Oversensitivity to rejection
___Oversensitivity to criticism
___Lack of interest in my usual activities
___Hopelessness
___Mood swings
___Overly high energy level for my age
___Perfectionism
___Sexual drive—lack of
___Feeling that others are out to get me
___Feeling that others are watching me
___Hearing voices

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BEHAVIORAL ISSUES
___I drink alcohol more than 2 nights per week
___At least one day a week, I have 4 drinks or more (if female) or 5 drinks or more (if male)
___I have used an illegal drug in the last month
___I smoke at least one cigarette per week
___At least once a week, I drink more than 2 cups of coffee, OR more than 4 colas or cups of tea
___I have had a DUI (When? _____)
___I have been charged with a crime in the past (other than parking, speeding or DUI)
___Aggressive or violent thoughts or behaviors
___Arguing
___Compulsive behaviors (Please specify: _____)
___Repetitive behaviors (e.g. hand washing, checking doors, checking stove)
___Cutting or otherwise injuring self
___Other self-harm in past (Describe: _____)
___Decision making problems, indecision, mixed feelings, putting off decisions
___Disorganization
___Gambling
___Irritability
___Impulsiveness
___Irresponsibility
___Judgment problems, risk taking
___Self-neglect, poor self-care
___Suicide attempt in past (When? _____)
___Temper problems, self-control, low frustration tolerance

EATING/WEIGHT ISSUES
___Lack of appetite
___Weight loss (How much? _____ Over what time? _____)
___Overeating
___Weight gain (How much? _____ Over what time? _____)
___Vomiting
___Taking laxatives, enemas or diuretics to lose weight
___Bingeing on food
___Diet issues
___Fear of becoming fat

SLEEP ISSUES
___Sleeping too much
___Insomnia
___Difficulty going back to sleep upon awakening during night
___Too much worrying or thinking keeps me from getting to sleep
___Waking at least 2 hours too early in the morning
___Feeling extremely restless or squirmy prior to bedtime
___I have taken a sleeping pill or drank alcohol to sleep at least once in the past month
___Nightmares or upsetting dreams
___Suddenly falling asleep in inappropriate locations
___Snoring
___Grinding teeth during sleep
___Stopping breathing briefly during sleep (noticed by you OR partner)
___Sleepwalking

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ANY OTHER CONCERNS OR ISSUES THAT MAY BE A FOCUS FOR PSYCHOTHERAPY?:

_____

_____

_____

_____

WHICH CONCERNS DO YOU MOST WANT HELP WITH?
1.

2.

3.

INFORMATION CHECKLIST
Please review the following list of treatments you may have had in the past. Please put a check next to any that apply to you and indicate the dates, to the best of your recollection.

			Dates:
Inpatient psychiatric hospitalization	___ No	___Yes	_____
Intensive outpatient treatment (e.g. at least 2-3 days per week)	___ No	___Yes	_____
Psychotherapy	___ No	___Yes	_____
Outpatient Substance Abuse counseling	___ No	___Yes	_____
Attending AA/NA/CA meetings	___ No	___Yes	_____
Taking medication for emotional difficulty	___ No	___Yes	_____
Taking medication for sleep	___ No	___Yes	_____

PSYCHOTROPIC MEDICATIONS
_____ I do not take psychotropic medications
Psychiatrist _____ Phone _____ Fax _____
Address _____
If you enter treatment with me for psychological problems, I strongly recommend that treatment be coordinated between your psychiatrist and me. Do you have any problems with this? ___ No ___Yes

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EDUCATION

Did you graduate from HIGH SCHOOL? ____ Yes ____ No
Year of graduation _____

COLLEGE OR VOCATIONAL SCHOOL Attendance and Degrees/Certificates:

From	To	School	Degree Program	Did you graduate?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

EMPLOYMENT for the last 5 years

Dates From	To	Name of military or employers	Job title or duties	Reason for leaving
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past:

____ My parents/caretakers punished me physically as a child or teenager
____ My parents/caretakers were verbally harsh and critical of me as a child or teenager
____ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection.
____ My parents/caretakers were unaware of my difficulties when I was a child or teenager.
____ There was violence in my home growing up.
____ I experienced inappropriate sexual contact as a child or teenager
____ I experienced sexual harassment as an adult
____ I experienced other upsetting sexual experience(s) as an adult
____ As an adult, I experienced a physical injury intentionally caused by another adult.
____ Someone has hit, kicked, punched or otherwise hurt me during the last 12 months.
____ Someone has threatened me verbally with bodily harm.
____ I experienced any other upsetting experience(s) as noted below:

_____
_____

PRESENT RELATIONSHIP

____ I do not have a partner at present
How would you characterize your relationship with your partner? _____
_____

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USE OF CAFFEINE, ALCOHOL, TOBACCO AND STREET DRUGS

How much coffee, cola, tea, or other sources of caffeine do you consume each day?

_____

_____

ALCOHOL

1. Have you ever felt the need to cut down on your drinking? ___ No ___Yes
2. Have you ever felt annoyed by criticism of your drinking? ___ No ___Yes
3. Have you ever felt guilty about your drinking? ___ No ___Yes
4. Have you ever taken a morning "eye-opener"? ___ No ___Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average?

_____

6. How much TOBACCO do you smoke or chew each week?

_____

7. Which STREET DRUGS have you used in the last 3 years?

_____

LEGAL ISSUES

1. Are you presently suing anyone or thinking of suing anyone? ___ No ___Yes
If yes, please explain:

_____

2. Is your reason for coming to see me related to an accident or injury? ___ No ___Yes
If yes, please explain:

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?
___ No ___Yes If yes, please explain

_____

4. Have you had any contacts with the police, courts, and jails/prisons regarding a crime that you were charged with? ___ No ___Yes
5. Were you ever locked up in jail or prison--even if just overnight? ___ No ___Yes
6. Are there any other legal involvements I should know about? ___ No ___Yes
If yes, please describe:

_____

MEDICAL HISTORY

1. Please list all CURRENT MEDICAL PROBLEMS that you have (Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes, etc.).

_____

_____

_____

2. Please rate your current level of PHYSICAL PAIN on a scale of 0-10, with 0 being no pain and 10 being the worse pain you have ever had _____
Rate the most severe pain you have had in the past month ____
Why were you experiencing pain? _____

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3. List all MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS, AND OVER-THE-COUNTER DRUGS you have taken in the last month.

Medication/drug	Dose (how much?)	Taken for	Prescribed by

4. Have you had any SURGERIES, including any plastic surgery? If so, please list briefly:

_____
_____

5. Have you ever been hit or injured on the HEAD? ___ No ___Yes
Have you ever been knocked UNCONSCIOUS? ___ No ___Yes
Please describe:

_____
_____

HEALTH HABITS

1. What kinds of physical exercise do you get?

_____
_____

2. How many times per week do you typically exercise for 20 minutes or more? _____

3. Do you try to restrict your eating in any way? How? Why?

_____
_____

4. Do you have any problems getting enough sleep?

_____
_____

5. What is your average number of hours of sleep per night? _____