Name/Date____

PERSONAL HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to obtain a comprehensive picture of your general background. This will help better facilitate your therapy. Your answers to these routine questions may provide a clue to things related to your problems that might otherwise go unnoticed. Because this information is highly person, it is understandable that you may be concerned about the information you share. All answers are strictly confidential. No outsider is permitted to see your record without your written permission.

Part 1. Personal Review

What concerns prompt you to seek counseling? Be specific. ____

____

Describe the problems that you are experiencing that are associated with the above. ______________________

____

How long have you had these concerns? ____

Have things gotten worse, better, or stayed the same since it started? In what way? ______________________

____

What is the longest period of remission and/or relief that you have experienced from this problem? ____________

____

In your opinion, what do you think is the cause of your problem? ________________________________

____

Have you attempted to solve this on your own? If so, how? ____________________________________

____

State the names and dates of the professional people you have consulted about this issue: __________________

____

In your own words, how would you like to be helped?____

____

____

____

____

____

____

____

____

Part 2. Description Of Current Problems

Circle any of the following that apply to you:

☐Overeating	☐Suicidal attempts	☐Can't keep job	☐Take drugs	☐Compulsive behavior
☐Insomnia	☐Vomiting	☐Smoking	☐Gambling	☐Odd behavior
☐Lazy	☐Withdrawal	☐Nervous tics	☐Eating problems	☐Take too many risks
☐Over drink	☐Work too hard	☐Can't concentrate	☐Too aggressive	☐Procrastinator
☐Crying	☐Sleep disturbance	☐Impulsive reactions	☐Temper outbursts	☐Fear of loss of control

Which of the above would you like to change?______________________________

What in life would you like to do more of? ______________________________

What would you like to do less of? ______________________________

What would you like to start doing? ______________________________

What would you like to stop doing? ______________________________

How do you like to spend your free time? ______________________________

What are some talents/skills that you feel proud of? ______________________________

Do you practice relaxation regularly? If so, how? ______________________________

Circle any of the following feelings which frequently apply to you during an average week:

☐Angry	☐Guilty	☐Unhappy	☐Annoyed	☐Happy	☐Bored	☐Sad
☐Conflicted	☐Restless	☐Depressed	☐Regretful	☐Lonely	☐Anxious	☐Hopeless
☐Contented	☐Fearful	☐Hopeful	☐Excited	☐Panicky	☐Helpless	☐Optimistic
☐Energetic	☐Relaxed	☐Tense	☐Envy	☐Jealous	☐Other______________	

What feelings would you like to experience more often? ______________________________

What feelings would you like to experience less often? ______________________________

When are you most likely to lose control of your feelings? ______________________________

Describe any situations which make you feel calm or relaxed. ______________________________

Complete this sentence: "If I were to get angry with you, I would ______________________________

What kinds of hobbies do you enjoy or find relaxing? ______________________________

Do you have trouble relaxing and enjoying weekends/vacations? *If yes, please explain:* ______________________________

List three fears you have, in order of importance: ______________________________

____

Part 2. Description Of Current Problems (continued)

Circle any of the following that often apply to you:

☐Headaches	☐Stomach trouble	☐Skin problems	☐Dizziness	☐Tics
☐Dry mouth	☐Palpitations	☐Fatigue	☐Burning/itchy skin	☐Muscle spasms
☐Twitches	☐Chest pains	☐Tension	☐Back pain	☐Rapid heart beat
☐Tremors	☐Flushes	☐Sexual disturbances	☐Blackouts	☐Unable to relax
☐Fainting spells	☐Dislike being touched	☐Hear things	☐Bowel disturbances	☐Watery eyes
☐Tingling	☐Visual disturbances	☐Numbness	☐Night sweats	☐Hearing difficulties

What sensations are especially pleasant for you? ______________________________

What sensations are especially unpleasant for you? ______________________________

IF YOU ARE FEMALE, PLEASE ANSWER THESE QUESTIONS ABOUT YOUR MENSTRUAL HISTORY:

How old were you when you had your first period? ______________________________

Were you informed or did it come as a shock? ______________________________

Are you regular? __________ Date of last period __________ Duration ______________________________

Do you experience pain? ______________________________

Describe how your periods affect your mood. ______________________________

Describe how your periods affect your energy. ______________________________

Part 3. Thoughts & Images

Sometimes thoughts, memories, and images come into our mind that we don't plan on. Other times we bring thoughts and pictures into our mind that we enjoy. Please circle any of the following that apply to you:

☐Pleasant sexual images	☐Unpleasant sexual images	☐Unpleasant childhood images
☐Lonely images	☐Helpless images	☐Seductive images
☐Aggressive images	☐Thoughts of being loved	☐Being hurt
☐Hurting others	☐Not coping	☐Being in charge
☐Succeeding	☐Failing	☐Losing control
☐Being trapped	☐Being followed	☐Being laughed at
☐Being talked about	☐Being promiscuous	☐Other ______________________

Write the ones from above which come into your mind most often. ______________________________

____

Part 3. Thoughts & Images (continued)

Describe a very pleasant image, mental picture, or fantasy:____

____

Describe a very unpleasant image, mental picture, or fantasy: ____

____

Describe your image of a completely "safe place": ____

____

Do you have nightmares? ☐yes ☐no If yes, how often?____

Check any of the thoughts that apply to you:

☐I am worthless, a nobody, useless and/or unlovable.

☐I am unattractive, incompetent, stupid and/or undesirable.

☐I am evil, crazy, degenerate, and/or a deviant.

☐Life is empty, a waste, there is nothing to look forward to.

☐I make too many mistakes, can't do anything right.

Circle each of the following words which you might use to describe yourself:

☐intelligent	☐confident	☐worthwhile	☐ambitious	☐sensitive	☐loyal	☐trustworthy
☐full of regrets	☐worthless	☐a nobody	☐useless	☐evil	☐crazy	☐considerate
☐deviant	☐degenerate	☐unattractive	☐unlovable	☐inadequate	☐confused	☐ugly
☐stupid	☐naive	☐honest	☐incompetent	☐conflicted	☐attractive	☐horrible thoughts
☐suicidal	☐humorous	☐witty	☐indecisive	☐persevering	☐hardworking	☐memory lapses

What do you consider to be your most irrational thought or idea? ____

____

Are you bothered by thoughts that occur over and over? If so, describe: ____

____

Complete the following sentences:

I am a person who ____

Ever since I was a child ____

It's hard for me to admit ____

One of the things I can't forgive is ____

A good thing about having problems is ____

A bad thing about growing up is ____

One of the things I could help myself in, but don't is ____

Part 3. Thoughts & Images (continued)

On each of the following items, please circle the number that most accurately reflects your opinions, using the scale below:

1: strongly disagree 2: mildly disagree 3: neutral 4: mildly agree 5: strongly agree

Item					
I should not make mistakes.	1	2	3	4	5
I should be good at all I do.	1	2	3	4	5
When I do not know, I pretend that I do.	1	2	3	4	5
I should not disclose information about my personal life.	1	2	3	4	5
I am a victim of circumstances.	1	2	3	4	5
My life is controlled by forces beyond my control.	1	2	3	4	5
Other people are happier than I am.	1	2	3	4	5
It's important to please others.	1	2	3	4	5
Play it safe; take no risks.	1	2	3	4	5
I don't deserve to be happy.	1	2	3	4	5
If I ignore my problems, they will go away.	1	2	3	4	5
It's my responsibility to make other people happy.	1	2	3	4	5
I should strive for perfection.	1	2	3	4	5
There are two ways of doing things: the right way and the wrong way.	1	2	3	4	5

Part 4. Your Family History

What were your parents' attitudes toward their pregnancy with you?____

____

Any pregnancy complications? (bleeding, excessive vomiting, medication, infections, x-rays, parental smoking/alcohol/drug use, etc.).

____

____

Any known birth problems, trauma, forceps or complications? If so, please describe. ____

____

If you were not brought up by your parents, who raised you, and between what years? ____

____

Give a description of your father's (or father-substitute) personality and of his attitude toward you. ______________________________

____

Part 4. Your Family History (continued)

Describe your mother's (or mother-substitute) personality and her attitude toward you. ____

____

Describe how you were disciplined and/or punished by your parents as a child. ____

____

Give an impression of the home you grew up in, describing how you recall parents and children getting along. ____________________

____

Were you able to confide in your parents? ____

____

Did your parents understand you? ____

____

Basically, did you feel loved and respected by your parents? ____

____

If you have/had a stepparent, how old were you when your real parent remarried? ____

____

Does anyone (parents, relatives, friends) interfere with your marriage, occupation, choice of where you live, etc.? ________________

____

Part 5. Your Friendships

Do you make friends easily? Do you keep them? *(describe)* ____

____

Were you ever bullied or severely teased? ____

____

Describe any relationship that gives you joy. ____

____

Describe any relationship that gives you grief. ____

____

Circle the words which best describe the way you generally feel in social situations:

very relaxed relaxed comfortable so-so uncomfortable

Circle the words which best describe the way you generally express your feelings, wishes, and opinions to others:

very open somewhat open somewhat careful very careful

Part 5. Your Friendships (continued)

Describe those individuals and/or situations in which you have trouble expressing yourself. ___

___

Did you date much during high school and/or college? Describe your experiences. ___

___

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? ___

___

Part 6. Your Sexual History

Describe your parents' attitude toward sex. ___

___

Was sex ever discussed in your childhood home? ___

___

When and how did you derive your first knowledge of sex? ___

___

When did you first become aware of your sexual impulses? ___

___

Have you ever experienced any anxiety or guilt feelings arising out of sex or masturbation? If yes, please explain. ___

___

Please share any important details regarding your first or subsequent sexual experiences. ___

___

Your age at the time of your first sexual experience: ___ Number of past sexual partners: ___

Which gender do you prefer for your sexual partner? (Check all that apply.) ☐male ☐female ☐transgender

With which sexual orientation do you most closely identify? ☐gay ☐straight ☐bisexual ☐other___

Is your present sex life satisfactory? If not, please explain. ___

___

Please provide any information, if any, about any problems in your current and past sexual relationships. ___

___

Please describe any sexual problems not discussed/mentioned above. ___

___

Part 6. Your Sexual History (continued)

Do you have any history of a sexually transmitted disease? If so, please specify:____

____

Do you have any history of any unwanted sexual experience (rape, molest, sexual abuse, etc.)? _________________________________

____

Do you have any history of being physically abused? If so, please describe: ____

____

Do you have any history of being emotionally abused? If so, please describe:____

____

Part 7. Your Marriage/Partnership History

How long did you know your spouse/partner before you moved in together? ____

____

How long have you been married/lived together? ____

What is the age of your partner/spouse? occupation? ____

Describe your spouse's/partner's personality. ____

____

In what areas do you feel compatible? ____

____

In what areas do you feel incompatible? ____

____

Describe how you get along with your spouse's/partner's family (parents, brothers, sisters): _____________________________________

____

How many children do you have? Please give their names, ages, and gender. ____

____

Do any of your children have a special need or problem? ____

____

Please share any information regarding abortions or miscarriages, if applicable. ______________________________________

____

Part 8. Other History

What is currently stressful in your life? (e.g, relationships, work, school, finances, children, health, etc.): ________________________

____

Any history of head trauma, concussion or significant accidents? (describe):____

____

Ever any seizures or seizure like activity?____

____

Hospitalizations (please list place, cause, date, outcome): ____

____

Abnormal lab tests, X-rays, EEG, etc:____

____

Allergies/drug intolerances (describe):____

____

What is your height?________ What is your current weight?_________ Is this what you want it to be? _________________________

____

Check any of the following which apply to your sleep behavior:

☐sleepwalking ☐nightmares ☐recurrent dreams ☐problems waking ☐problems getting to sleep

☐snoring ☐staying asleep ☐wake up panicked ☐narcolepsy ☐other______________________________

____

Any history of legal problems? If so, what kind? What was the outcome?____

____

What is your highest diploma/degree?____

Average grades received _________________ Any learning disabilities? If so, please describe:_________________________________

____

Any problems in school? If so, please describe:____

____

Please describe your favorite job that you've ever held, and why:____

____

Please describe your least favorite job you've ever held, and why:____

____

Part 8. Other History (continued)

Any history of work-related problems? If so, please describe:______________________________

____

Did you serve in the military? If so, when & where? With which service?______________________________

____

Any military-related injuries? If so, please describe:______________________________

____

Have you ever experienced withdrawal symptoms from alcohol or drugs?______________________________

____

Has anyone told you they thought you had a problem with alcohol or drugs?______________________________

____

Have you ever felt guilty about your alcohol or drug use? ______________________________

____

Have you ever felt annoyed when someone talked to you about your alcohol or alcohol use? ______________________________

____

Have you ever used alcohol or drugs the first thing in the morning?______________________________

____

Caffeine use per day (cups of coffee or tea, cans of soda, amount of chocolate)______________________________

____

Nicotine use per day, past and present, (how many cigarettes or cigars, how much chew) ______________________________

____

Part 9. Your Medications/Supplements

Please list medications/supplements, including dosages, effectiveness and any side-effects. Please list all taken currently as well as in the past. If you need more room, please attach another sheet.

Date Taken	Medication include dose & frequency	Effectiveness	Side-Effects & Problems
Example: **03/10 to 05/12**	*Example:* **Zoloft 10 mg daily**	*Example:* **Improved mood through the day.**	*Example:* **Problems with orgasm.**

Please bring pertinent medical records to your appointment, such as lab results, psychological testing, etc.

This is the end of this questionnaire. Thank you for your help.