Bressler Counseling

Introductory Questionnaire For Therapy

This questionnaire is designed to build a foundation for therapy. By responding to these questions as thoroughly as you can, you will be:

- *Helping me get to know you in a comprehensive way*
- *Providing a historical background for present concerns*
- *Highlighting your main concerns*
- *Clarifying current concerns*
- *Helping me to know what might be ruled out diagnostically*
- *Preparing to develop a therapeutic plan*

Some questions may not pertain to you – simply draw a line through them. Please answer all questions that are applicable completely. If there is a question you do not wish to answer in writing, discuss that with me when we meet.

General Information

Name_____ DOB_____ Age_____

Address_____ City_____ Zip_____

Phone (home)_____ (work)_____ (cell)_____

Email address_____

Emergency Contact Name_____Phone_____

How were you referred?_____

Martial Status _____If Married, Spouse's Name_____ Age_____

Occupation_____Employer_____

Do you have children? Y__ N__ Stepchildren? Y__ N__ Grandchildren? Y___ N___

Name _____ Gender_____ Age_____

Name _____ Gender_____ Age_____

Name _____ Gender_____ Age_____

Present Issues

Please state your main concern(s) in your own words:_____

_____

_____

Please indicate how distressing your concern is right now:

1	2	3	4	5	6	7	8	9	10
Mild		Moderate			Very		Extreme		Totally upsetting

When did this begin? Give dates if possible: _____

_____

Please describe any events that you believe brought on this issue or that keep it going: _____

_____

_____

How have you tried to resolve this concern? _____

How was that helpful? _____

What obstacles remain? _____

Have you been in therapy before or received any prior professional or support group assistance for your concern? If so, what was helpful at that time? _____

_____

_____

Family of Origin History

Number of siblings: _____

Name_____ Age_____ Closeness of relationship_____

Name_____ Age_____ Closeness of relationship_____

Name_____ Age_____ Closeness of relationship_____

Name_____ Age_____ Closeness of relationship_____

Name_____ Age_____ Closeness of relationship_____

Other family members you feel contributed to your life in a significant way either bad or good: Give name, relationship and describe:_____

_____

_____

Father's History

Name _____Living? Y N Age_____ Health_____

Occupation _____

If deceased: What was his age and cause of death? _____

What was your age at the time of his death? _____

Indicate any mental or physical problems your father has/had: Circle and/or describe

Depression Anxiety Other Mental Illness_____

Physical Illness_____ Drinking problems Drug problems

Suicidal thoughts/attempts if yes/when? _____

Other_____

_____

Mother's History

Name _____Living? Y N Age_____ Health_____

Occupation _____

If deceased: What was her age and cause of death? _____

What was your age at the time of his death? _____

Indicate any mental or physical problems your mother has/had: Circle and/or describe

Depression Anxiety Other Mental Illness_____

Physical illness_____ Drinking problems Drug problems

Suicidal thoughts/attempts if yes/when _____

Other_____

_____

Parents' Marital History

Are your parents currently married? Y N If no, has either of your parents remarried? Y N

How old were you when they were divorced or widowed? _____

Was either parent previously married? Y N

Spiritual History

Your religion as a child _____ As an adult _____

Church affiliation_____ Pastor's Name _____

How would your describe your current spiritual/religious experience?_____

_____

_____

Would you consider your faith a personal strength? Y N

If you have ever experienced spiritual abuse, please describe here: _____

_____

_____

Nationality

Do you affiliate with a nationality or country of origin? Y N If yes, please describe:_____

_____

Childhood and Adolescence

Circle any of the following that applied during your childhood or adolescence to you or anyone in your family:

happy	unhappy	emotional issues	eating disorder
family problems	physical abuse	alcohol abuse	sexual abuse
verbal abuse	legal problems	drug abuse	school problems
medical problems	financial problems	abortion	

If you circled any problems above, or there is something else not listed here, please explain:_

_____

_____

_____

If you were not raised by your biological parents, who helped raise you? _____

_____ Between what ages/years? _____

Please describe your **father's** (or father substitute's) personality and his methods of discipline (past & present):_____

_____

How did he show affection and how often did he share his affection with you? _____

_____

In what ways did he influence you or others members of the family? _____

_____

Please describe your **mother's** (or mother substitute's) personality and her methods of discipline (past & present): _____

_____

How did she show affection and how often did she share her affection with you? _____

_____

In what ways did she influence you or others members of the family?_____

_____

What were the standard emotional overtones in your family while you were growing up? _____

_____

Has any member of your family had significant problems? If yes, please describe: _____

_____

Has any relative expressed suicidal thoughts or behaviors? If yes, please describe: _____

_____

Has any relative had serious problems with the law? If yes, please describe:_____

_____

Physical Health

What is your height? _____ Weight? _____ Describe any recent changes: _____

_____

Do you have or have you ever had any of the following?

Illnesses or physical conditions Surgeries Unusual sensations

Unusual physical characteristics Troubling physical symptoms

Please describe anything circled above or if there is anything not listed: _____

_____

Current medications:_____

Prescribed by: _____

Allergies (food, medication, environmental):_____

_____

Name and phone number of your family physician: _____

_____

Date of most recent complete physical examination:_____Results:_____

How would you describe your overall health?_____

Educational

Please name the last completed grade/degree(s) and what school:_____

Specialized areas of study:_____

Current educational activities: _____

Do you have a documented or suspected learning disability? Y N If yes, describe _____

_____

Occupational

What sort of work are you currently doing?_____

In what ways does your present work satisfy or not satisfy you? Please describe:_____

_____

_____

What were your past ambitions or dreams? _____

What are your current ambitions or dreams? _____

What kinds of hobbies or leisure do you enjoy or find relaxing? _____

_____

Has there been any recent change to your interest in, frequency of participation in these

activities? Y N If yes, what is the reason? _____

_____

Financial

Is your household income sufficient to live on? Y N

If your concerns include financial issues, please describe:_____

_____

Behavioral

Please circle and describe any of the following behaviors that apply to you:

overeating	odd behavior	phobic avoidance	aggressive behavior
vomiting	nervous tic	insomnia	outbursts of temper
loss of control	procrastination	smoking	laziness
drinking too much	working too much	drug use	can't keep a job
compulsions	risk taker	impulsive reactions	eating problems
crying	withdrawal	sleep disturbance	
concentration problems		gambling	

other _____

Have you been hospitalized for psychological or emotional problems? Y N If so, when and where? _____

Sexual

Please describe your parents' attitude toward sex:_____

Was sex discussed in your home? _____

When and how did you derive your first sexual knowledge? _____

When and how did you first be come aware of your own sexual impulses? _____

_____

Have you experienced anxiety or guilt feelings arising out of sex or masturbation? Please describe: _____

_____

Are your first or subsequent sexual experiences relevant? Y N In what way? _____

_____

Is your present sex life satisfactory? Please describe: _____

_____

Please describe any sexual concerns not discussed above: _____

_____

Your current family

Whom do you include in the group you consider your "family"? _____

_____

How would you describe your current family? _____

What are the prevailing emotional overtones in your family? _____

_____

Are there any changes you'd like to see happen in your family? _____

_____

Marriage

How long did you know your spouse before your engagement? _____

How long were you engaged? _____How long have you been married?_____

Were either of you married before? If yes, please describe: _____

_____

If previously married, for how long?_____ How soon were you remarried?_____

How would you describe your relationship with your spouse? _____

_____

Friendships

Do you make friends easily? Y N How are your friendships important to you? _____

_____

Rate the degree to which you generally feel comfortable and relaxed in social situations:

1 2 3 4 5 6 7 8 9 10

Very relaxed Relatively comfortable Uncomfortable Very anxious

Stress

Check any of the following that apply. Please indicate those you consider important, and those occurring over the past six years.

Death in the family	Miscarriage	Divorce
Trouble with the law	Financial trouble	Job/School problems
Serious illness	Serious operation	Abortion
Mental illness	Alcohol problems	Drug problems
Interpersonal problems	Sexual abuse	Depression
Physical abuse	Suicidal thoughts	Suicidal attempts
Spiritual problems	Anger management	Unresolved conflict

Please describe if you circled any of the above. Indicate the person involved such as a spouse, child, father, mother, brother, sister, yourself, etc.:_____

_____

_____

Other Influences (outside of your immediate family)

How do you relate with your in-laws? _____

Have your parents, relatives, or friends sought to influence your situation? Y N

Please describe: _____

_____

_____

Is your job or school situation unusually stressful? Y N

Please describe: _____

_____

Please describe:_____

Have the police or other social agencies influenced your family? Y N

Please describe:_____

Have there been any other significant outside influences on your family? Y N

Please describe:_____

Expectations regarding therapy

In a few words, what do you think therapy is all about? _____

_____

How long do you think therapy should last? _____

How do you think a therapist should interact with clients? _____

_____

How would you describe a desired outcome for therapy? _____

_____

Please use this area to describe any other related matters you may have that have not been addressed by this questionnaire.

_____

_____

_____

_____

_____

_____

The information contained herein is complete and truthful to the best of my ability.

Signature_____ **Date**_____