BACKGROUND QUESTIONNAIRE

This is a confidential record of your personal history. By completing these questions as fully and as accurately as you can, you will help to facilitate the counseling process. Use the back of the page if necessary.

Name: _____Date:_____

Address:_____

Relationship History

Marital Status: Single Engaged Married Separated Divorced Widowed

Your Age: _____ Spouse Age:_____ Date of marriage:_____

If separated from spouse, since what date?:_____

If divorced please list the following information:

Date of marriage(s) to ex-spouse(s):_____

Date of divorce(s):_____

If involved with a "significant other": His/her name_____

Level of satisfaction in relationship 1 (low) – 10 (high): _____

Have you ever had / or are having any extramarital affairs?_____

List the following information about each child.

Name	Age	Relationship (biological, step child, adopted, foster)	Living with?

Other adults living with you?_____

Describe current friendships in your life and the level of support you have outside your immediate family:

_____

_____

_____

Do you make friends easily?:_____

Were you ever bullied or severely teased?:_____

How relaxed and comfortable do you feel in social situations?:_____

_____

Do you have one or more friends with whom you feel comfortable sharing your inner thoughts and feelings? If so, who?:_____

_____

Generally, do you express your feelings opinions and wishes to others easily?: _____

Describe any situations in which you have trouble expressing yourself fully:_____

_____

_____

Employment History

Last grade completed:_____

Present or future educational goals:_____

What sort of work do you do now?:_____

What kinds of jobs have you held in the past?:_____

Does your present work satisfy you? Why or why not?:_____

_____

Are finances a current stress for your family?:_____

General Health History

Family Physician:_____

Date of last physical exam:_____

How often do you exercise?:_____What types of exercise?:_____

Do you sleep well?: Yes / No How many hours of sleep a night? (average):_____

Explain sleep problems, if applicable:_____

Have there been recent changes in your weight? Describe:_____

Are you concerned about your weight or have eating / food issues?:_____

How often do you experience the following?

	Never	Seldom	Sometimes	Often	Explain
Insomnia	_____	_____	_____	_____	_____
Body pains	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____
Fears	_____	_____	_____	_____	_____
Compulsions	_____	_____	_____	_____	_____
Nausea	_____	_____	_____	_____	_____
Allergies	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____
Loss of temper	_____	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Loss of Appetite	_____	_____	_____	_____	_____
Over-eating	_____	_____	_____	_____	_____
Bingeing/Purging	_____	_____	_____	_____	_____
Mood swings	_____	_____	_____	_____	_____
Impulsive actions	_____	_____	_____	_____	_____
Loss of memory	_____	_____	_____	_____	_____
Frequent crying	_____	_____	_____	_____	_____
Dizziness	_____	_____	_____	_____	_____
Heart palpitations	_____	_____	_____	_____	_____
Sexual difficulties	_____	_____	_____	_____	_____
Avoidance of touch	_____	_____	_____	_____	_____
Trouble concentrating	_____	_____	_____	_____	_____
Unable to relax	_____	_____	_____	_____	_____
Hearing things	_____	_____	_____	_____	_____
Shame/embarrassment	_____	_____	_____	_____	_____
Panic Attacks	_____	_____	_____	_____	_____
Zone out/ time loss	_____	_____	_____	_____	_____

List any significant Physician diagnoses, surgeries or prominent medical conditions:_____

_____

_____

List any current medication(s):_____

_____

Name and phone of prescribing Doctor:_____

How often do you drink alcohol:_____ Caffeine:_____

Explain any past history of drug usage / abuse:_____

Mental Health History

Have you had any previous counseling or psychotherapy?

Name of Therapist:_____Length of treatment:_____

Was the therapy helpful? Why or why not?:_____

_____

Have you ever been diagnosed with a mental health condition? If so, what?:_____

_____

Have you taken medication for emotional problems in the past?: _____

If so, list name of drug(s), dates taken, and name of doctor: _____

_____

Have you ever been violent? _____

Have you ever been or currently are suicidal?_____ Homicidal?_____

If so, explain:_____

Have you ever been hospitalized for psychological problems?:_____

If so, When?:_____Length:_____

Have you ever had any physical or emotional traumatic events in your life? If so, please explain: _____

_____

_____

_____

Family History

Describe your family-of-origin (the family you grew up in):_____

_____

_____

_____

Are your parents still living?:_____

Where do they live?:_____

Are you emotionally close to them?:_____

Are they divorced?:_____

How many siblings do you have?:_____Where are you in the birth order?:_____

How did you and your siblings get along in the past?:_____

_____

How do you and your siblings get along at the present time?:_____

_____

Has any member of your family (including extended family) ever suffered from anything which could be described as an emotional, psychological or chemical dependency problem? (ex: Alcohol, drugs, depression, suicide-attempted or committed, etc) _____

Relative_____Problem_____

Relative_____Problem_____

Relative_____Problem_____

Spiritual History

Religious Affiliation:_____ Church Home:_____

Do you participate in any activities that enrich your spiritual life? If so, what: _____

_____

Are their areas of change you desire in your spiritual life?:_____

_____

How have your current problems impacted your spiritual life? _____

_____

What role, if any, would you like spirituality/faith to have in your current therapy experience? _____

_____

Goals for Therapy

Please give a description of your current problem(s) and your reasons for seeking help at this time:

_____

_____

_____

_____

How would you rate how serious this problem feels to you? (Circle one)

1 2 3 4 5
Mildly Upsetting Extremely Serious

When did this problem begin?:_____

Describe any events or life stresses that may relate to the development of or maintenance of the problem:

_____

_____

_____

How would you know that therapy has been helpful for you?:_____

_____

What would you guess is your partner's main goal for therapy? *(if applicable):*_____

_____

Is there anything else you want your therapist to know at this time?:_____

_____

_____

_____

Print Name:_____

Signature:_____ Date:_____