DIRECTIONS

**THIS ASSESSMENT QUESTIONNAIRE IS MEANT TO HELP YOU REVIEW EVERY ASPECT OF YOUR CURRENT LIFE.**

Not all of the questions are for you. If they do not relate- skip it. It might be useful to print this out and just use it to consider what might be uncomfortable for you. I DO need basic info of parents, children's names. We will review before we start. DO Not get worried or annoyed by the length of this. You may need to come back to it several times to consider or use this as a prompt.

Place of Birth: Date of Birth:

Significant moves in your life ( locations and ages )

Define and discuss problems of social development; adjustment to life situations [i.e. school, peer groups, community, family relationships, response to authority figures, use of leisure time]:

Cultural influences; ethnic factors which may be significant for you or other members of family / spouses:

**EDUCATION:**

Please circle the last year of school that you completed: High School College- what degree Master's Doctorate

Did you leave home to attend college?

My grades were / were not significant: Attitude towards school and teachers?

Extra-Curricular Activities: Band/Choir Theater Arts Creative Arts Class Officer Sports Other

**THIS FAMILY OF ORIGIN:**

Is your father living? (circle) No Yes

If no, year of death: His age at time of death: Cause of death: Your age at the time of his death:

If yes, how old is he now? How is his health?

Describe your father's occupation when you were growing up:

Circle the last year of school that your father completed: Grade School High School College Master's Doctorate

When you were growing up was your father a/an: Alcohol or drug addict/abuser Food addict/abuser

Physical/sex/other abuser Prescription drug addict/abuser Violent Absent

Describe your father's personality and his attitude towards you as you were growing up. What is his name?

How would you describe your relationship with your father now? Skip if deceased. Excellent Good Average Below average Poor

Is your mother living? If no, year of death: Age: If no, cause of death: If no, your age at the time of her death:

If yes, how old is she now? What is her name?

Describe your mother's occupation when you were growing up:

Circle the last year of school that your mother completed: Grade School High School College Master's Doctorate

When you were growing up was your mother a/an: Alcohol or drug addict/abuser Food addict/abuser

Physical/sexual/other /abuser Prescription drug addict/abuser Violent Absent Overprotective

Give a description of your mother's personality and her attitude toward you as you were growing up.

How would you describe your relationship with your mother now? Skip if deceased. Excellent Good Average Below average Poor

How would you describe your family's attitude toward you when you were growing up? Please explain.

Were your parents ever separated or divorced? No Yes If yes, how old were you at the time? Please describe your home atmosphere as you were growing up. Mention state of compatibility between parents and between parents and children.

Who raised you as a child?

How many brothers and sisters do you have?

Number of Brothers Cause of death living or deceased cause of death

Names

Number of Sisters Cause of death living or deceased cause of death

Names

What is your usual living arrangement?

What is your present marital status?

Living alone Married Living with partner Living with a roommate/partner Separated Separated Living with a spouse Divorced Living with family; specify; Widowed Never married Living with others; specify: Living in a communal society; specify: Please provide the following information for each marriage:

Start Date

End Date

Name of Spouse

Reason for Termination [Death, Divorce, etc.]

Number of Children from this Marriage

Names of Children

Please answer the following questions about your spouse/partner. If not currently married, but previously married, answer the following questions about your former spouse/partner

Is/was your spouse employed? No Yes

When employed, what kind of work did your spouse do?

Please circle the last year of school that your spouse completed: Grade School High School College Master's Doctorate

**SEXUALITY:**

What was your parents' attitude about sex?

When and how was your first knowledge of sex?

When did you first become aware of your sexual impulses?

Have you ever thought you needed help for your sexual thoughts or behaviors? Yes No If yes, please explain:

Do you ever resort to sex to escape, relieve anxiety, or cope with stressful situations? Yes No If yes, please explain:

Have you ever been arrested for a sex related offense? Yes No If yes, please explain:

Have you noticed physical symptoms such as nausea, knot in your stomach, or hot flashes when approached sexually? Yes No If yes, please explain:

How old were you when you masturbated for the first time? years old. How old were you when you had an orgasm for the first time? years old. How old were you when you had sexual intercourse for the first time? years old.

Did you ever have any anxiety or guilt feelings about masturbation or having sexual intercourse? If yes, please explain.

Have you been sexually abused or raped? If yes, please explain. By whom?

Have you been in recovery for sexual abuse? How long?

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

Have you ever had an abortion? Yes No What age? Please explain.

How many children do you have (including children from previous marriages whether they are living with you or not)?

sons living deceased

daughters living deceased

Concerns with children

**VOCATION/EMPLOYMENT:**

Are you employed? Yes No Name of employer?

Briefly describe the kind of work you do.

How long have you done this kind of work? years

Does your present work satisfy you? Yes No If not, in what ways are you dissatisfied?

What would you like to do?

What jobs have you held in the past?

What were your vocational ambitions now?

What is the total annual income of your family? Check ONE Under $12,000 Between $12,000 and $20,000 Between $20,000 and $35,000 Between $35,000 and $60,000 Over $60,000

Branch of Service? Rank? Type of Duty? Length of Service? Type of Discharge? Adjustment to Military Life?

Injuries?

**LEGAL DIFFICULTIES:**

DUI? Yes No If Yes, please explain and give dates. Other difficulties including lawsuits, legal guardianship, custody of minor child(ren).

RELIGION/SPIRITUALITY: Do you believe in God? Yes No

In what religion were you raised? Catholic Muslim Jewish Hindu Protestant specify: Agnostic Fundamental Protestant specify: No Religion Buddhist Other specify:

Which describes best how you feel about your religious upbringing? Religion was beaten into me Religion was a good experience I am angry about being forced to go to church I am grateful for my religious upbringing My religious upbringing is irrelevant to my life I have no particularly strong feelings about my religious upbringing

As a child, I understood God as being: Loving and generous Wrathful and angry Everywhere as in nature but powerless to help me Removed from my daily life Could not imagine God Wanted to believe in God but had difficulty God? Who cares?

As a child, my greatest religious concern was: Heaven and hell Guilt and punishment Love and grace Satan/the devil and evil Being good or being bad Fearful of God's punishment Death I had no religious concerns

How did your parents respond to your grief? They ignored it They helped me through it and comforted me They told me to stuff my feelings They got angry at my feelings They showed disgust at my feelings They did not see me or my feelings [I felt invisible]

Do you feel your faith or religion has been: A vital part of your life Important, but not vital Something you can take or leave The source of all your problems Have had no faith or religion or as an adult

Please explain:

Now I understand God as being Loving and generous Wrathful and angry Everywhere as in nature but powerless to help me Removed from my daily life Can not imagine God Want to believe in God but have difficulty God? Who cares?

This is similar to or Different from my childhood belief.

Which of the following contributes to your inability to find peace of mind? Hopelessness Despair Depression Resentment Self-hate Constant lying Lack of discipline Sex issues Impatience Other specify:

Do you feel you have done something that is so bad you cannot be forgiven? Yes No Please explain.

**HOBBIES/INTERESTS:**

What are your present interests, hobbies and activities?

How much time do you spend in leisure activities? Do you prefer spending leisure time alone or with others? Why?

How is most of your leisure time occupied?

What would you like to change about your leisure time and the way it is spent? Please explain.

**PSYCHIATRIC HISTORY:**

Does anyone in your family have a psychiatric illness, such as depression, alcoholism, drug dependence or an eating disorder? Please give details.

Are there any other members of the family about whom information regarding illness, etc., is relevant?

List any situations that make you feel stressed.

List any situations, which make you feel calm or relaxed.

**MEDICAL HISTORY:**

What are your present medical concerns?

What are your past medical comcerns?

What medication or drugs are you taking? Please list names and amounts, including any for weight control and including birth control pills, recreational and CBD.

Are you allergic to any medication, drugs or foods? No

If yes, please list which and what reaction you have; e.g. "rash".

**ADDICTIONS** current or history:

Where do you think your addictions currently show up?

Are you currently an Alcoholic Recovering alcoholic Drug addict Recovering drug addict Prescription drug addict Recovering prescription drug addict Food addict Recovering food addict Anyone in your family?

How many cups of coffee do you drink daily? Six cups or more Three to five cups One or two cups None

How many cups of soda do you drink daily? Six cans or more Three to five cans One or two cans None

Are they "diet" sodas? Yes No Are they caffeine free? Yes No

How many hours of sleep do you need to feel your best? Ten hours or more Eight to ten hours Six to eight hours Less than six hours

Check one: I get enough sleep. I do not get enough sleep. I sleep too much

How would you describe your overall physical health? Check one Excellent Better than average Average Worse than average Poor List health problems or symptoms:

**MENSTRUAL HISTORY: [MALES SKIP]**

How old were you when your first menstrual period began? years old Not Applicable [for females who have never menstruated]

Are you on birth control? Yes No

How many times have you missed your period for 2 consecutive months or more (excluding pregnancy)? Times Never

Please complete the following for each time your menstrual period stopped: Most Recently Previous Time Previous Time Previous Time Date

EXCEPT for any times when your periods may have stopped because of a major weight loss or gain, what is the approximate regularity of your periods?

Fairly regular [same number of days, not more than 3 days early, late]

Somewhat irregular [within 4 to 10 days early or late] Very irregular [more than 10 days early or late]

Menppause or perimenopause (year and any current experiences)

NOT COUNTING HOSPITALIZATION FOR CHILDBIRTH, please list all hospitalizations, indicating your age and the reason for each admission:

**AGE REASON FOR HOSPITALIZATION**

Please list any serious illnesses you have had which DID NOT REQUIRE HOSPITALIZATION: AGE ILLNESS

Have you ever received psychiatric therapy or are you now receiving psychiatric therapy?

No, never Yes, in the past. Why?

Yes, at present. Why?

Please complete the section below regarding your psychiatric therapy. Age Reason for Contact Type of Therapy Received Length of Treatment

ATTITUDE TOWARD PRESENT LIFE SITUATION:

Please check the following responses that apply to you: take sedatives feel panicky suicidal ideas sexual problems inferiority feelings over-ambitious shy with people unable to have a good time can't make decisions home conditions bad concentration difficulties don't like weekends & vacations headaches palpitations bowel disturbances nightmares feeling tense depressed eat too much dizziness stomach trouble fatigue

can't make friends can't keep a job financial problems unable to relax fainting spells no appetite insomnia alcoholism tremors take drugs memory problems

Others:

worthless inadequate can't do anything right horrible thoughts guilty agitated repulsive confused useless stupid full of regrets hostile cowardly ugly lonely attractive a "nobody" incompetent evil full of hate

unassertive deformed unloved worthwhile life is empty naive morally wrong considerate bored in conflict

intelligent confident misunderstood unconfident sympathetic anxious panicky unattractive restless fat

**DO YOU HAVE A HISTORY OF:**

Heart Disorders Diabetes Asthma/Emphysema Cancer Other Lung Disorders Aids/HIV High Blood Pressure Any Implants Rheumatoid Arthritis Broken Bones Stress Related Tension Back Problems Circulatory Disorders Neck Problems Migraine Headaches Recent Fever Tension Headaches Recent Pain Recent Infections Chronic Pain Psychological Disorder Blood Clots Kidney Disorders TMJ Problems Nervous Disorders Numbness Sinus Problems Dizziness Skin Allergies Edema Gastrointestinal Disturbances Respiratory Allergies Fluid Retention Loss of smell Hay fever Loss of taste Tightness of throat Inflammation/throat Thyroid trouble Face Flushed Twitching of face Loss of memory Fatigue Depression Head feels heavy Fainting Loss of balance Ringing in ears Light bother eyes Grating in neck Tightness of shoulder muscles Neuritis in shoulder & arms Pins & needles in arms & hands Cold hands Chest pains Seizures Shortness of breath T.B Heart palpitation Heart attacks High blood pressure Low blood pressure Anemia Rheumatic fever Nervous stomach Stomach trouble Ulcers Irritability Cold sweats Liver trouble Gall bladder trouble Indigestion Constipation Bladder trouble Sleeping problems Swollen joints Pins & needles in legs Cold feet Pains in legs & feet Phlebitis

Varicose veins Shoulder pain Knee pain Weight control Stress Post stroke symptoms Hormone balance Energy build-up Stimulation of hair growth Insomnia Hepatitis G.I. Problems Urinary problems Muscular/Skeletal Venereal disease Epileptic Sensitive to touch/in any area Wear contact lenses

MALES ONLY: FEMALES ONLY: Prostate trouble Easily fatigued Urination difficulty Pre-menstrual stress Frequent night urination Tension Burning upon urination Depression Persistent abdominal pain Painful menstruation cramps Pain on inside of legs or heels Menstruation excessive & prolonged Pain in groin area Menstruation scanty or missing Low back pain Vaginal Discharge Tire too easily Painful breasts Lack of energy Menopausal hot flashes, etc. Excessive perspiration Melancholia of long standing Diminished sex drive I.U.D. diaphragm Burning or pain during orgasm Birth control pills Are you pregnant?

SURGERIES