Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional**

\_\_\_ feeling depressed, sad

\_\_\_ feeling anxious, tense, uptight

\_\_\_ feeling guilty or ashamed

\_\_\_ feeling worthless

\_\_\_ being afraid of things

\_\_\_ worrying too much

\_\_\_ spells of terror or panic

\_\_\_ feeling angry, hostile

\_\_\_ feeling easily annoyed or irritated

\_\_\_ having uncontrollable temper outbursts

\_\_\_ crying frequently

\_\_\_ blaming myself for things

\_\_\_ feeling that things are unreal

\_\_\_ feeling of being trapped or caught

\_\_\_ thinking about ending my life

\_\_\_ wanting to hurt someone else

\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cognitive**

\_\_\_ having trouble concentrating

\_\_\_ having trouble remembering

\_\_\_ feeling blocked in getting things done

\_\_\_ having to double-check everything I do

\_\_\_ difficulty making decisions

\_\_\_ hearing things that others do not hear

\_\_\_ having the same thought over and over

\_\_\_ afraid that I am losing my mind

\_\_\_ having thoughts that are not my own

\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical**

\_\_\_ being tired, having no energy

\_\_\_ sleeping too much or too little

\_\_\_ appetite increased or decreased

\_\_\_ frequent headaches

\_\_\_ nausea or upset stomach

\_\_\_ having many health problems

\_\_\_ chronic illness or pain

\_\_\_ physical disability

\_\_\_ loss of sexual interest or pleasure

\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavioral**

\_\_\_ smoking too many cigarettes

\_\_\_ using drugs or alcohol

\_\_\_ having an affair

\_\_\_ not getting enough exercise

\_\_\_ having poor eating habits

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ not making time for leisure activities

\_\_\_ not having any hobbies

\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Family/Social

\_\_\_ having marital problems

\_\_\_ having difficulties with children

\_\_\_ punishing my children too much

\_\_\_ having problems with parents

\_\_\_ being physically abused

\_\_\_ being emotionally abused

\_\_\_ having sexual problems

\_\_\_ not getting along with other people

\_\_\_ having my feelings easily hurt by others

\_\_\_ feeling that most people cannot be trusted

\_\_\_ not having close friends

\_\_\_ feeling shy or uncomfortable around others

\_\_\_ feeling like people are against me

\_\_\_ feeling different from everyone else

\_\_\_ feeling that friends have let me down

\_\_\_ feeling guilty or confused about religion

\_\_\_ other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Recent Stresses

\_\_\_ not having a job

\_\_\_ being afraid I will lose my job

\_\_\_ problems with supervisor or co-workers

\_\_\_ job too stressful

\_\_\_ working too many hours

\_\_\_ not having enough money

\_\_\_ involved in lawsuit

\_\_\_ facing criminal charges

\_\_\_ friend or relative seriously ill

\_\_\_ friend or relative has died

\_\_\_ friend or relative emotionally upset

\_\_\_ victim of accident

\_\_\_ victim of crime

\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Previous Experience with Therapy

\_\_\_ none

\_\_\_ individual counseling or psychotherapy

\_\_\_ group therapy

\_\_\_ marital, couple or family therapy

\_\_\_ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_