HISTORY AND PERSONAL DATA QUESTIONNAIRE

Today's Date_____

Main reason for seeking counseling_____

CURRENT PROBLEMS OR SYMPTOMS

Please read each item below and determine which statement is true for you. Then, place an "X" in the appropriate box to indicate how often you feel the statement applies to you during the past month. Please be sure to rate every item.

EXAMPLE:

	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	MOST OR ALL OF THE TIME
1. I FEEL SAD		**X**	

DURING THE PAST MONTH	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	MOST OR ALL OF THE TIME
A. **1.** WAKE UP AT NIGHT OR IN THE EARLY MORNING AND UNABLE TO RETURN TO SLEEP			
2. VERY RESTLESS SLEEP			
3. LOSS OF ENERGY			
4. DECREASED SEX DRIVE			
5. UNABLE TO ENJOY LIFE; HAVE LOST ZEST FOR LIFE			
6. HAVE WITHDRAWN FROM OTHERS			
7. STRONG THOUGHTS OF SUICIDE			
8. LOSS OF APPETITE			
9. MEMORY PROBLEMS, FORGETFULNESS, POOR CONCENTRATION			

10. WEIGHT LOSS:

HOW MUCH IN THE PAST MONTH?_____LBS.

WEIGHT GAIN

HOW MUCH IN PAST MONTH?_____LBS.

HAVE YOU BEEN TRYING TO DIET? _____YES _____NO

DURING THE PAST MONTH	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	MOST OR ALL OF THE TIME
B. **11.** DECREASED NEED TO SLEEP			
12. INCREASED SEX DRIVE			
13. INCREASE ENERGY			
14. SO HAPPY THAT PEOPLE DESCRIBE ME AS MANIC			
C. **15.** CANNNOT GET TO SLEEP			
16. SUDDEN EPISODES OF NERVOUSNESS OR PANIC			
17. FEAR OF LOSING SELF-CONTROL			
18. PALPITATIONS OR RAPID HEART BEAT			
19. SHORTNESS OF BREATH			
D. **20.** STRANGE OR UNUSUAL THOUGHTS			
21. HALLUCINATIONS, HEAR VOICES OR SEE THINGS THAT ARE NOT THERE			
22. VERY PECULIAR EXPERIENCES			
23. READY TO EXPLODE			
24. THOUGHTS ABOUT HARMING SOMEONE			
25. EXCESSIVE USE OF ALCOHOL/DRUGS			

PREVIOUS TREATMENT FOR EMOTIONAL PROBLEMS

YEAR	PROBLEM	THERAPIST/LOCATION	HOSPITALIZATION/TREATMENT

ALL CURRENT MEDICATION	DOSAGE	SCHEDULE	DOCTOR

MEDICAL INFORMATION

HAVE YOU EVER BEEN DIAGNOSED AS HAVING THE FOLLOWING? **Circle all that apply.**

HEART TROUBLE VASCULAR DISEASE MIGRAINES HIGH BLOOD PRESSURE ALS

FIBROMYALGIA CHRONIC FATIGUE CANCER THYROID DISEASE MS

ULCERS HEAD INJURY LUPUS DIABETES OTHER_____