

# INITIAL INTERVIEW FORM

**Today's Date:** \_\_\_\_\_

All questions contained in this questionnaire are confidential and will become part of your clinical record.

<b>Name</b> <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M	<input type="checkbox"/> F	<b>DOB:</b>		<b>Age:</b>	
<b>My Reason for Coming in Now:</b>							

## PRESENTING PICTURE

<b>My main symptoms are related to:</b>	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Obsessive Worries <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Confusion <input type="checkbox"/> Drug Use <input type="checkbox"/> Focus/Inattention <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Mood Swings <input type="checkbox"/> Self Worth <input type="checkbox"/> Spiritual Issues <input type="checkbox"/> Relationships <input type="checkbox"/> Sex Life <input type="checkbox"/> Memory Issues <input type="checkbox"/> Anger <input type="checkbox"/> Compulsive Behavior <input type="checkbox"/> Work/Professional <input type="checkbox"/> Other:						
<b>The major stressor (s) that precipitated my symptom (s): (Please include start dates)</b>	<input type="checkbox"/> Marital Issues		<input type="checkbox"/> Parent/Child Issues				
	<input type="checkbox"/> Job Stress		<input type="checkbox"/> Past Issues <i>Abuse, Guilt, Family of Origin</i>				
	<input type="checkbox"/> Health Issues		<input type="checkbox"/> Other:				
<b>My three biggest worries at present are:</b>							
1.							
2.							
3.							

## DETAIL OF CURRENT SYMPTOMS – Check all that apply

Please add clarifying notes as necessary.

<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Sad Mood	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Increased Crying	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Low Motivation	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Poor Concentration	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Sleep Pattern (+/-)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Appetite Change (+/-)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Weight Change (+/-)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Lack of interest in Enjoyable Activities	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Decreased Self-Esteem	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Feeling Helpless/Hopeless	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Lack of Interest in Pleasurable Activities	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Bad Dreams or Troubling Thoughts ( <u>underline which</u> )	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Suicidal Thoughts or Past Attempts? ( <u>underline which</u> )	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Thoughts of, or actual self-harming behaviors ( <u>underline which</u> )	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Violent Thoughts	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Avoiding People/Situations	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Inattention or Hyperactivity ( <u>underline which</u> )	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Fear of Others (their plans or actions to hurt me)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Seeing or Hearing what no else reports seeing or hearing ( <u>underline which</u> )	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Excited mood with racing thoughts, increased speech, decreased sleep, increased activity	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Energy level: Increased and/or Decreased ( <u>underline which</u> )	

<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Anxious/Worried Thoughts and/or Strong Fear/s (underline which)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Rapid Heartbeat and/or Chest Discomfort	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Increased Sweating	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Shortness of Breath	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Dizziness or Disorientation	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Abdominal (stomach) Distress	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Recurring Thoughts or Mental Images that I Cannot Control (underline which)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Feeling Very Powerful or Exceptional	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Fear of "Going Crazy"	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Chills, Hot Flashes, Night Sweats	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Intense Irritation and/or Angry Outbursts	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Fatigue/Low Energy	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Hyper vigilance – excessive focus on all external and internal stimuli	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Obsessions and/or Compulsions – repetitive checking, washing, counting; invasive thoughts	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Avoidance of things/places associated with a traumatic experience	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Agoraphobia – fear of places or inescapable situations	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Specific Phobia – marked and persistent fear of certain objects or situations	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Social Phobia – marked and persistent fear of social or performance situations	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Fears/Anxiety Related to a Traumatic Event	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Flashbacks or Persistent Nightmares	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Isolating Self from Contact with Others	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Impaired concentration or Thought Process	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Impaired Memory and/or Amnesia (underline which)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Running Away	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Oppositional or Defiant Behaviors	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Truancy or Missing Work	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Somatization (physical symptoms/health worries with no medical explanation)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Agitation/Irritability (easily annoyed or provoked)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Substance Abuse (current)	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Behavioral Problem:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Developmental or Learning Issue:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Eating Issues:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Legal Issues:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Sexual Issues:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Marital Issues:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Parenting Issues:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Family Issues:	
<input type="checkbox"/> Sometimes <input type="checkbox"/> Weekly <input type="checkbox"/> Daily	Other:	

**Past History (past issues that may be relevant now)**

A. Have you had similar and significant symptoms in the past?  Yes  No. If yes, when:

Did they recently increase?  Yes  No. If yes, when & what caused it?:

B. Please name three past stressful events in your life that precipitated the original symptoms (s):

C. Prior Psychiatric Hospitalizations?  Yes  No. If yes, when:

Reason for hospitalization:

D. Past Counseling History?  Yes  No. If yes, please list therapist, reason, & date range:

E. Substance Abuse History?  Yes  No. If yes, when started:

Substances:

Treatment Location and Dates:

F. Have you experienced any physical, sexual, verbal, or emotional abuse?  Yes  No. If yes, please list:

G. Any Head/Brain Trauma (concussion, asphyxia, other injury?)  Yes  No. If yes, please list:

H. Have you ever attempted suicide?  Yes  No. If yes, please explain:

**Prescribed Psychiatric Medications (Current)**

Medication & Dosage	Reason Taken?	Reactions/Side Effects?	Date Prescribed?

I am currently taking the following over the counter medications:

Supplements:

Significant Allergies:

**Employment History (last three employers)**

Employer	Dates Employed	Reason for leaving?	Notes

## PERSONAL HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4-5x/week for 30-50 minutes)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 5-7x/week for 50+ minutes)			
<b>Sleep</b>	<input type="checkbox"/> Insomnia (no consistent or sound sleep)			
	<input type="checkbox"/> Little Sleep (i.e., 2-4 hours per day)			
	<input type="checkbox"/> Limited Sleep (i.e., 4-6 hours per day.)			
	<input type="checkbox"/> Regular Sleep (7 hours or more per day on average)			
<b>Diet</b>	Are you dieting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you have concerns about your eating patterns or habits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes: Height/Weight: _____ # of meals you eat in an average day?			
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?			
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever "passed out" or experienced blackouts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Do you occasionally "binge" drink?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you driven after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
<b>Drugs</b>	Do you currently use recreational and/or illegal drugs/substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Have you ever given yourself drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Frequency? _____ Concerns? _____			
	Any discomfort or dysfunction with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Spirituality</b>	How do you identify spiritually/religiously? (i.e., Christian, atheist, Hindu, etc....):			
	Would you say you have a personal relationship with Jesus Christ?	Yes	No	If so, how long?
	Do you attend a church (name...)?	Yes	No	If so, how often?
	Do you pray and/or meditate?	If so, how often?		
	Do you read/study the Bible?	If so, how often?		
	Do you have personal concerns or questions related to God, the Christian faith, and/or the church?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you open to discussing relevant matters of faith with your therapist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

FAMILY DETAIL			
	DOB & AGE	NAME	RELEVANT NOTES
<b>Father</b>			
<b>Mother</b>			
<b>Siblings</b>	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
	<input type="checkbox"/> M		
<input type="checkbox"/> F			
<b>Your Current Marital Status:</b>	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Other:		<b># of Marriages:</b>
<b>Spouse</b>			
<b>Children</b>	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
	<input type="checkbox"/> M		
	<input type="checkbox"/> F		
<b>Grandmother</b> <i>Maternal</i>			
<b>Grandfather</b> <i>Maternal</i>			
<b>Grandmother</b> <i>Paternal</i>			
<b>Grandfather</b> <i>Paternal</i>			
<b>Were your Parents Divorced?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No. <b>If yes, when:</b>		<b>Parents Remarried?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No.	
<b>Previous Spouse (s)</b> ( or cohabitant)			Reason for ending relationship...

COUPLES	
<b>Our primary issues are related to:</b>	<input type="checkbox"/> Communication <input type="checkbox"/> Anger management <input type="checkbox"/> Guilt <input type="checkbox"/> Time management <input type="checkbox"/> Parenting Conflicts <input type="checkbox"/> Dishonesty <input type="checkbox"/> Sexual Connection <input type="checkbox"/> Flirting <input type="checkbox"/> Emotional Infidelity <input type="checkbox"/> Physical Infidelity <input type="checkbox"/> Spiritual <input type="checkbox"/> Leadership <input type="checkbox"/> Structural (family relationships) <input type="checkbox"/> Structural (definition of marriage) <input type="checkbox"/> Finances <input type="checkbox"/> Other:
<b>What have been the recent events leading up to seeking couple's counseling now?</b>	
1.	
2.	
3.	
<b>Our three primary goals for marriage counseling are (in order):</b>	
1.	
2.	
3.	
<b>When did you first think your problems were serious enough for couple's counseling...? Date:</b>	
<b>Date met current spouse:</b>	<b>Dating?:</b>
<b>Engaged?:</b>	<b>Married?:</b>
<b>Seperated?:</b>	
<b>Premarital Counseling (date)?</b>	
<b>Previous Marriage Counseling?</b>	
<b>Other Relevant Notes:</b>	

