CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

Name: _____ Date of Birth: _____ Age:_____ Date:_____
Address: _____

The following information will be helpful to us in determining how to best help you with your concerns. Please fill out this form as completely as you can, and bring it to your first appointment. Use additional space if necessary.

BASIC BACKGROUND INFORMATION:

Education/Vocation:_____
Years of education completed: _____ Highest degree obtained: _____
Current Occupation: _____ Employer: _____

Marital Status:

____ Never married ____ Living together ____ Divorced
____ Married ____ Separated Dates of marriage if divorced:
____ Engaged ____ Widowed _____ to _____

Children:

Name Date of Birth School grade/occupation

_____
_____
_____
_____

PHYSICAL HEALTH:

Please describe any prior or ongoing physical health conditions that you have:

_____
_____
_____
_____

Please provide the following information on any medications that you are currently taking:

Name of medication	Dosage	Reason for medication

LEGAL HISTORY:

Have you ever been convicted of a felony or misdemeanor? YES NO
If yes, please indicate the charge(s) and
dates:_____
_____

CHEMICAL USE HISTORY:

Do you use alcohol? YES NO

If yes, frequency and amount: _____

Do you use tobacco? YES NO

If yes, frequency and amount: _____

Do you use any other street drug: YES NO

If yes, list the type of drug and indicate the frequency and amount:

_____

_____

_____

PRIOR TREATMENT HISTORY:

Have you ever been hospitalized for a psychiatric condition? YES NO

If yes, please indicate the dates and place of hospitalization:

_____

_____

Have you been involved in counseling or psychotherapy previously? YES NO

If yes, please indicate the following:

Reason	Dates of Service	Place of service or provider	Helpful?
			YES NO
			YES NO
			YES NO

FAMILY HISTORY:

Indicate any family history of mental health or addiction history. Leave blank if no relevant history.

Mother: _____

Father: _____

Sibling(s): _____

Child(ren): _____

Other or extended family members:

_____

_____

CURRENT DIFFICULTIES:

Describe briefly how you have been feeling lately.

_____

_____

_____

Have there been any stressors or events in your life that have impacted your mood lately? If so, what have they been?

_____

Please indicate YES or NO to those statements that reflect how you have been feeling lately. Indicate YES if you have been experiencing these symptoms *nearly every day,* NO if you have not been experiencing these symptoms or if you have been experiencing them less frequently.

Have you been feeling depressed or sad?	YES	NO
Have you found it more difficult to enjoy your usual activities?	YES	NO
Have you had a change in your appetite?	YES	NO
Have you had a change in your weight?	YES	NO
Have you been dieting in an attempt to lose weight?	YES	NO
Have you had difficulties with your sleep?	YES	NO
If yes, have you had difficulties falling asleep?	YES	NO
If yes, have you had difficulties staying asleep?	YES	NO
If yes, have you had difficulties with early morning awakening and being unable to fall back asleep?	YES	NO
Have you felt like you needed more sleep than usual?	YES	NO
Have you been tired or experienced low energy?	YES	NO
Have you had excessive feelings of worthlessness or low self-worth?	YES	NO
Have you had feelings of guilt?	YES	NO
Have you noticed decreased ability to concentrate or pay attention?	YES	NO
Do you notice that you have more difficulties than usual making decisions?	YES	NO
Have you experienced recurrent thoughts about your death?	YES	NO
Have you recently thought about taking your own life?	YES	NO
Have you ever attempted suicide?	YES	NO
Have you noticed a decrease in your interest in sexual activity?	YES	NO
Have you experienced an increase in bodily aches and pains?	YES	NO
Have you had problems with anger or irritability?	YES	NO
Have you felt like you are moving in "slow motion?"	YES	NO
If yes, is it noticeable to others?	YES	NO
Have you felt like you are restless, or that you physically can't sit still?	YES	NO
If yes, is it noticeable to others?	YES	NO

Please note any patterns you may have noticed with respect to changes in your mood:

_____

_____

Have you ever had a period in your life where your mood was extremely elevated, you felt that you had the world "by the tail," went for periods where you went without needing much sleep, or engaged in behaviors that others considered were "over the top?" YES NO

Do you have any fears or phobias? YES NO

If yes, list: _____

Do these ever interfere with your life or ability to do things: YES NO

Do you consider yourself a worrier? YES NO

If yes, what types of things do you worry about?

_____

_____

Do you find it hard to control or stop worrying? YES NO

Is your worrying associated with any of the following?

____ Restlessness or feeling "on edge"
____ Fatigue or tiredness
____ Poor concentration or your mind "going blank"
____ Irritability
____ Physical tension
____ Sleep problems

Do you ever "worry yourself sick?" YES NO

If yes, please explain: _____

Do you have thoughts that pop into you head that you can't control and that bother you? YES NO

If yes, are these thoughts that you think most other people would have ("normal worries")? YES NO

If yes, do you find it hard to ignore these, even if you try? YES NO

Do you have any behaviors that you feel like you have to do, have to repeat, or that you have to do in a certain way? YES NO

If yes, what are these?

_____

_____

If yes, does doing the behavior make you feel better? YES NO

Do you feel anxious in situations where there are a lot of unfamiliar people or where you think you may be evaluated or that you will do something embarrassing? YES NO

If yes, have you ever avoided situations as a result? YES NO

Would you say that this has caused problems for you? YES NO

Do you ever have periods of intense fear or panic attacks? YES NO

If yes, do these come "out of the blue?" YES NO

If yes, note which symptoms are prominent for you:

____ Heart palpitations	____ Sweating	____ Trembling/Shaking
____ Shortness of breath	____ Smothering sensation	____ Choking sensation
____ Chest pain/discomfort	____ Nausea/upset stomach	____ Dizziness/feeling "faint"
____ Feelings of unreality	____ Fear of going crazy	____ Feeling detached from yourself
____ Fear of losing control	____ Fear of dying	____ Numbness/tingling sensations
____ Hot or cold flushes		

How long do these periods usually last? _____

Have you ever had anxiety about going someplace/doing something because of these symptoms? YES NO

When did these first occur (and what was going on at the time)?

_____

Have you ever been exposed to a situation where you thought you could have been seriously hurt or injured?
YES NO
If yes, describe the situation.

_____

_____

_____

What emotions are associated with this event for you? _____

Do you ever have recurrent or distressing thoughts about the event? YES NO

Do you have recurrent bad dreams about the event? YES NO

Do you ever feel like you are "reliving" the event? YES NO

Are there any "triggers" for your distress? YES NO

If yes, explain what they are: _____

If yes, explain what happens to you when this occurs:

_____

_____

Indicate which of the following are true for you since the event:

____ I avoid thinking or having conversations about the event
____ I avoid activities, people, or places associated with the event
____ I am not really interested in things that I used to be
____ I really can't recall things about the event
____ I don't really feel like I can relate to others
____ I don't experience much emotion
____ I don't think about my future much

Note which of the following are true for you since the event:

____ I am "jumpy" or easily startled
____ I am "on edge" and wary of threats
____ I am more irritable or have anger outbursts
____ I don't concentrate very well
____ I have troubles with my sleep

What are your goals for your involvement in psychotherapy?

_____

_____

_____

_____

Is there anything specifically in addition to the above questions that you want to make sure the psychologist seeing you visits with you about?

_____

_____

_____

_____

Thank you for filling out this form.