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Initial Meeting Information

Please fill out this questionnaire in as much detail as you feel comfortable. There may be things you do not know or cannot remember. That is fine. If you need to use the back or additional paper in answering a question, go right ahead. This is NOT a test. It is an effort to save you time in the initial stage of therapy by getting as much history as possible early on. Only answer what you are ready to answer. If you are experiencing a difficulty, we are bound to find that out together sooner or later. Thanks!

Date:_____
Name:_____
Address:_____
Home Phone:_ _____ Work Phone:_____
Email address:_____
Fax Number (if applicable):_____
Place of Employment/School:_____
No. Hours per Week:_____
Date of Birth:_____Age:_____
Marital Status:_____ No. Previous Marriages:_____
Name of Spouse:_____
Spouse's Employer:_____
Children (names and ages):_____
Physician:_____ Psychiatrist:_____
Medication(s):_____

Allergies:_____
Referred by:_____
Notify in Case of Emergency:_____
Relationship:_____
Daytime phone:_____
Insurance Coverage: _____yes _____no Company:_____
Policy Number: _____ Social Security Number_____

Background History

Have you ever received psychological treatment before? _____yes _____no
If yes, where? _____ Student Health/Counseling Center
_____Mental Health Clinic
_____Private Therapist
_____In-Patient Hospitalization
_____Other (please specify) _____

Do you have a Judicial Record? _____yes _____no
If yes, what were the charges/conviction and sentencing? _____
Marital Status of Your Parents _____Married _____Separated _____Divorced
_____Father Deceased _____Mother Deceased _____Father Remarried _____Mother Remarried
Father's Occupation_____ Mother's Occupation_____
Mention anything significant about your relationship with your parents: _____
_____
_____

Education of Father:
_____Did not finish high school
_____High school graduate
_____Did not finish college
_____Graduate degree

Education of Mother:
_____Did not finish high school
_____High school graduate
_____Did not finish college
_____Graduate degree

Number of Brothers: _____
Older: _____
Younger: _____
Half: _____

Number of Sisters: _____
Older: _____
Younger: _____
Half: _____

Your overall birth order: _____
Mention anything significant about your relationship with your siblings: _____
_____
_____
Is there anyone else that played a significant role in your early family life (grandparents, aunts, uncles, family friends…)? If so, please elaborate: _____
_____
_____
_____
_____
What form(s) of discipline was used in your family?_____
_____
Who enforced the discipline used in your family? _____
_____
How was your living environment?_____
_____
What did you like most about your family?_____
_____
_____
What did you dislike most about your family? _____
_____
_____
Is there anything else you feel is important that has not been covered so far? _____
_____
_____

Do you consider yourself as having a problem with drugs or alcohol? _____yes _____no

Does anyone else consider your use of alcohol or drugs problematic? _____yes _____no

Has anyone in your family ever experienced substance abuse problems? _____yes _____no

Please mark the following:	Never Used	Stopped Using	Less than 3 Times/Week	More than 3 Times/Week
Your use of alcohol	_____	_____	_____	_____
Your use of marijuana	_____	_____	_____	_____
Your use of cocaine	_____	_____	_____	_____
Your use of other drugs (i.e. amphetamines, tranquilizers, hallucinogens)	_____	_____	_____	_____

Have you ever had an unwanted sexual experience (e.g. fondling, intercourse, rape, sexual harassment, etc.)? _____yes _____no If yes, check all that apply:

_____family member _____date or acquaintance
_____friend _____stranger
_____other (please specify)

Have you ever experienced difficulty with an eating disorder? _____yes _____no
If yes, check all that apply:

_____uncontrollable eating _____laxative use
_____rigid dieting _____other weight concerns
_____self-induced vomiting _____repeated fasting

Do you have any feelings (emotions) that you wish you could change? Please describe:
_____
_____

Do you have any behaviors that you wish you could change? Please describe:
_____
_____

Please name any significant changes in your life within the last six months:
_____
_____

What kind of support system do you have? _____
_____

Describe your living environment today? _____
_____

What are your goals for counseling? _____
_____
_____
_____

Emotional and Social Inventory

Circle the number that best fits your experience:	**1 None**	**2 A little**	**3 Some**	**4 Much**	**5 Very much**
Social Life and Relationship Skills					
Too little social life	1	2	3	4	5
Too much social life	1	2	3	4	5
Difficulty saying "no" to others	1	2	3	4	5
Difficulty meeting people	1	2	3	4	5
Have hard time with close relationships	1	2	3	4	5
Concerned about being racially harassed	1	2	3	4	5
Concerned about my sexual behavior	1	2	3	4	5
Difficulty communicating	1	2	3	4	5
Inability to make or keep friends	1	2	3	4	5
Hurting people's feelings	1	2	3	4	5
Feel like I don't fit in anywhere	1	2	3	4	5
Am considering ending a close relationship	1	2	3	4	5
Concerned about being sexually harassed	1	2	3	4	5
Am sexually inappropriate with others	1	2	3	4	5
Afraid of losing someone I love	1	2	3	4	5
Concerned about someone else's sexual behavior	1	2	3	4	5
Interpersonal conflicts	1	2	3	4	5
Worry about what others think of me	1	2	3	4	5
Overly concerned about personal appearance	1	2	3	4	5
Unable to control my anger	1	2	3	4	5
Physical Health Issues					
Feeling stressed	1	2	3	4	5
Nightmares/Restless sleep	1	2	3	4	5
Appetite Loss	1	2	3	4	5
Frequent headaches	1	2	3	4	5
Chronic or frequent illness	1	2	3	4	5
Weight concerns	1	2	3	4	5
Alcohol/Drug abuse	1	2	3	4	5
Lack of exercise	1	2	3	4	5
Too much energy	1	2	3	4	5
Under-eating	1	2	3	4	5
Overeating	1	2	3	4	5
Binging and purging	1	2	3	4	5
Concerns about sexually transmitted diseases	1	2	3	4	5

Concerns about Pregnancy	1	2	3	4	5

Emotional Health

Feeling sad often and for long periods	1	2	3	4	5
Feeling irritable	1	2	3	4	5
Angry outburst or prolonged anger	1	2	3	4	5
Feeling anxious	1	2	3	4	5
Extreme mood swings	1	2	3	4	5
Crying easily and often	1	2	3	4	5
Feeling depressed for long periods	1	2	3	4	5
Trust issues (too little, too much)	1	2	3	4	5
Suicidal thoughts	1	2	3	4	5
Have attempted suicide	1	2	3	4	5

Family Issues

Being criticized by my parents	1	2	3	4	5
Parent expectations of me too high	1	2	3	4	5
Parent's divorce/separation problematic	1	2	3	4	5
Concerned about past behavior of relatives, friends, or acquaintances	1	2	3	4	5
Sexual inappropriateness by family member(s)	1	2	3	4	5
My parents try to control me	1	2	3	4	5
Acute or chronic illness in family	1	2	3	4	5
Bothered by events of the past	1	2	3	4	5
Family non-supportive of my life choices	1	2	3	4	5
Concern about current family issues	1	2	3	4	5
Need parenting skills	1	2	3	4	5
Afraid of intimacy	1	2	3	4	5
Sexual problems in relationship	1	2	3	4	5

Thank your for your effort in filling out this questionnaire. It will save us valuable time in the counseling room. Feel free to address any or all of these issues with me as you feel comfortable. If there is anything I failed to ask but that you feel is important, please let me know here, in writing, or in the course of a session. I look forward to getting to know you and assisting you in any way that I can. Your questions and concerns are always welcome!

Sincerely,

Miriam Lieberman, MA, LPCS
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