Mountain View Therapy

Client Name: _____

Today's Date:_____ /_____ /_____

MEDICAL HISTORY

Height: _____ Weight: _____

Ethnic/Racial Identity: _____ If not born in the U.S., at what age did you come here? _____

Past Major Injuries/Accidents	When	Major Diseases, Illnesses, Operations	When
_____	_____	_____	_____
_____	_____	_____	_____

	NO	YES
1. Do you regularly take any over-the-counter medications (ex. To help you get to sleep, stay awake, reduce your appetite, combat headaches or deal with chronic stomach upset, etc.)?	_____	_____
2. Have you ever used laxatives or enemas on a regular basis?	_____	_____
3. Do you frequently have bouts of acid indigestion, stomach upset?	_____	_____
4. Do you frequently have severe headaches?	_____	_____
5. Do you have reoccurring pain in any area of your body (ex. neck, back, jaw)?	_____	_____
6. Have you suspected or been told that you or your partner was infertile?	_____	_____

(Questions 7-12 are for women only; men should skip to question #13)

7. Do you experience mood changes before or during your menstrual period?	_____	_____
8. Have you had problems with your menstrual period (ex. Irregular periods)?	_____	_____
9. Are you going through, or have you gone through menopause?	_____	_____

10. Number of pregnancies: _____ 11. Number of miscarriages, stillbirths, abortions: _____

12. Number of children placed for adoption: _____

13. Were you adopted? Yes No

14. Were your parents divorced? Yes No 15. If yes, how old were you when they divorced? _____

16. Is there any family history of any of the following (circle those that apply):

Depression:	None	Mom	Dad	Brother(s)	Sister(s)	Other_____
Other mental illness:	None	Mom	Dad	Brother(s)	Sister(s)	Other_____
Alcohol/drug abuse:	None	Mom	Dad	Brother(s)	Sister(s)	Other_____

17. Deceased Immediate Family (parents, siblings, children)	Year of Death	Cause of Death
_____	_____	_____
_____	_____	_____

PREVIOUS COUNSELING

When	Length	Ind./couples/family/group?	Main issue discussed	Helpful?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Psychiatric Medications: (do not include current meds)	Name of Drug	Years Taken	Taken for	Helpful?
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

	NO	YES
1. Do you often have difficulty falling or staying asleep, or have frequent nightmares?	_____	_____
2. Have you ever overexercised, fasted, or made yourself throw up to keep from gaining weight?	_____	_____
3. Do you often go on "binges," eating lots of junk food in one sitting, past the point of feeling full?	_____	_____
4. Are you easily distracted, finding it hard to stay focused on a task, or sit through a movie?	_____	_____
5. Have you been feeling depressed, a loss of pleasure, lack of energy, difficulty motivating yourself?	_____	_____
6. Have you ever had a panic attack (intense anxiety, difficulty breathing, heart pounding, feeling dizzy)?	_____	_____
7. Have you ever felt that people were "out to get you"?	_____	_____
8. Do you have recurrent disturbing thoughts or frightening images you can't get out of your mind?	_____	_____
9. Do you have recurrent distressing memories, flashbacks, or nightmares of a traumatic event?	_____	_____
10. Do you find yourself compelled to do unnecessary repetitive rituals (ex. repeatedly checking that you've locked a door, washing and rewashing your hands, repeated straightening, etc.)?	_____	_____
11. Do you work more than 40 hours a week, take work home with you, or work through meals?	_____	_____
12. Do you struggle with compulsive shopping, spending, or gambling?	_____	_____
13. Have you ever been hospitalized for mental or emotional problems?	_____	_____
14. Are you experiencing any problems with sexual arousal and/or functioning, or a lack of sexual desire?	_____	_____
15. Have you thrown/broken things, slammed doors, hit, pushed, slapped, or verbally berated someone?	_____	_____
16. Have you ever shaken a child in anger, or hit or spanked a child hard enough to leave a bruise?	_____	_____
17. Have you ever been sexually abused, raped, or forced to do sexual things you didn't want to do?	_____	_____
18. Have you ever been physically abused (ex. hit, shoved, pushed, slapped, or threatened with harm)?	_____	_____
19. Have you ever been verbally or emotionally abused (called names, degraded, made to feel inferior)?	_____	_____
20. Have you been in a relationship where you (or your children) were afraid, or were being abused?	_____	_____
21. Have you ever seriously thought of harming or killing yourself?	_____	_____
22. Have you ever had thoughts or fantasies of harming or killing someone else?	_____	_____

SUBSTANCE USE

How often do you drink alcohol? _____ Average drinks in one sitting? _____ Maximum in one sitting? _____

Recreational Drugs Used Now (ex. Marijuana, cocaine) How Often Used How Much Used in One Sitting

_____ _____ _____

_____ _____ _____

How often are you "high," buzzed, or intoxicated? _____ If in recovery, how long? _____

Number of caffeine drinks per day: _____

	NO	YES
1. Are you currently in a relationship with someone you think may have an alcohol or drug problem?	_____	_____
2. Have you ever worried that you might have a drug or alcohol problem?	_____	_____
3. Has anyone in your life ever complained or worried about your drinking or drug use?	_____	_____
4. Have you ever been treated for an alcohol or drug problem, gone to AA/NA, or quit on your own?	_____	_____
5. Have you ever used alcohol or drugs to help you get going in the morning, or while on the job?	_____	_____
6. Have you ever had hangovers, been late or missed work, forgot portions of the night before, or suffered other negative consequences after a night when you'd been drinking or using drugs?	_____	_____
7. Have you ever received a DUI, DWI or been stopped by the police for an alcohol-related inquiry?	_____	_____

RELATIONSHIP HISTORY

Previous Significant Relationships (start from most recent; do not include current relationship, if any):

Previous Partner's Name	Did You Marry?		Relationship Length	Who Ended It?	Why?
_____	Y	N	_____	_____	_____
_____	Y	N	_____	_____	_____

1. How long has your longest relationship lasted? _____ 2. How many times have you been married? _____
3. Names and ages of children not living with you (include adult children): _____ Age:_____,

_____ Age:_____, _____ Age:_____, _____ Age:_____

4. If not currently in a committed relationship, how long has it been since your last serious relationship? _____
5. If you are in a committed relationship, how long have you and your partner been together? _____
6. If currently married, how long have you been married? _____
7. If currently separated or divorced, how long have you been separated/divorced? _____
8. If currently a widow/widower, how long has it been since your spouse's death? _____
9. If married, and you had to do it over again, would you marry your current spouse, knowing what you know now?

Definitely Yes Yes Probably Not Sure Probably Not No Definitely Not

OVERVIEW

How satisfied are you with your:

1.	Job/career (include FT parent, housewife, student)?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied
2.	Financial situation?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied
3.	Relationship with your spouse/significant other?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied
4.	Relationship with your parents and siblings?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied
5.	Relationship with your children?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied
6.	Friendships (both quantity and quality)?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied
7.	Self?	Very Unsatisfied	Unsatisfied	Only OK	Satisfied	Very Satisfied

AREAS OF CONCERN

What issues/concerns causes you to seek treatment? Please describe. _____

_____

_____

_____

What are your specific goals with regard to your treatment? _____

_____

_____

_____

Do you have any particular concerns/fears with regard to treatment? _____

_____

_____

_____