

f. List age and reason for past mental health hospitalizations: _____

g. Have you ever attempted suicide? ___ No ___ Yes Explain:

RELATIONSHIPS

1. Relationship with yourself:

A. Personality (check any of the following words that you believe best describe you):

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> Hardworking | <input type="checkbox"/> Impatient |
| <input type="checkbox"/> Ambitious | <input type="checkbox"/> Self-confident | <input type="checkbox"/> Impulsive |
| <input type="checkbox"/> Persistent | <input type="checkbox"/> Nervous | <input type="checkbox"/> Often-blue |
| <input type="checkbox"/> Excitable | <input type="checkbox"/> Calm | <input type="checkbox"/> Imaginative |
| <input type="checkbox"/> Serious | <input type="checkbox"/> Easy-going | <input type="checkbox"/> Good-natured |
| <input type="checkbox"/> Shy | <input type="checkbox"/> Introvert | <input type="checkbox"/> Extrovert |
| <input type="checkbox"/> Likable | <input type="checkbox"/> Thick-skinned | <input type="checkbox"/> Quiet |
| <input type="checkbox"/> Leader | <input type="checkbox"/> Submissive | <input type="checkbox"/> Sensitive |
| <input type="checkbox"/> Self-conscious | <input type="checkbox"/> Lonely | <input type="checkbox"/> Moody |
| <input type="checkbox"/> Spiritual | <input type="checkbox"/> Assertive | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Hidden | <input type="checkbox"/> Other: _____ | |

B. Self-Care

a. List your hobbies: _____

b. How many hours per week do spend on your hobbies? _____

c. What unfulfilled dreams do you have? _____

d. Currently, what is/are your greatest personal need(s)? _____

2. Relationship with others:

A. Immediate Family

a. Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed ___ Other

b. List children and ages: _____

c. If in a committed relation, list any current relationship difficulties: _____

d. Are you experiencing any physical, emotional, or sexual abuse? ___ No ___ Yes (Explain) _____

e. How long have you been in your current relationship? _____

B. Family of Origin

a. Years parents were married? _____

b. Were both parents active in raising you? ___ No ___ Yes (Explain) _____

c. Is either parent deceased? ___ No ___ Yes How long? _____

d. List siblings' first names and ages: _____

e. Did you have any step-parents? ___ No ___ Yes _____

f. What age were you when your parent(s) remarried? _____

g. Mother's occupation: _____

h. Father's occupation: _____

i. If raised by someone other than parents/step-parents, who were they and how old were you when you lived with them?

j. What three words would you use to describe:

Your Father: _____ / _____ / _____

Your Mother: _____ / _____ / _____

k. Is there a history of substance abuse in your immediate or extended family? ___ No ___ Yes Briefly describe:

1. Is there a history of mental illness in your immediate or extended family? No Yes Briefly describe:

C. Social

a. How many close friends do you have? _____

b. Briefly describe any significant losses you have experienced and how old you were.

c. What is your sexual orientation? _____

d. What re-occurring relationship problems have you experienced?

e. Any sexual issues or problems:

f. List any community groups you are a member of (12-step, church, book club, etc.):

g. List any cultural issue or problems:

h. What strengths do you possess that build relationships?

LIFE FUNCTIONS

1. Education

a. List highest level of education completed. _____

b. List any other special training. _____

c. What degrees/training do you plan in the future? _____

2. Employment

a. List your current occupation: _____

b. How long have you been with current employer? _____

c. List other jobs you have held and how long. _____

d. What do you enjoy most about your work? _____

e. What aspects of your job cause you stress? _____

3. Legal

a. Have you ever had any major legal problems? Describe briefly.

4. Financial

a. List any financial difficulties you have had. _____

5. Faith

a. Do you consider yourself to be religious? ____No ____Yes. If yes, what is your denomination?

b. What religious disciplines do you practice? (prayer, meditation, fasting, etc.) _____

c. If you are not religious, do you consider yourself to be spiritual? ____ No ____ Yes

d. What spiritual expressions do you practice? _____

6. Wellness

a. How many times per week do you exercise? _____

b. What type of exercise do you do? _____

c. Describe any sleep problems: _____

d. Are you open to alternative treatments? (acupuncture, herbal medicine, etc.) ____ No ____ Yes

e. List any alternative practices you engage in: _____

f. Do you eat balanced, healthy meals and snacks? ____ No ____ Yes

g. What areas of wellness would you like to improve? Describe:

(Client signature)

(Date)