

History/Background

Name: _____ Date: _____

Describe the problem for which you seek therapy/consultation _____

Have you seen a therapist before about this problem (or about another issue)? _____

Education: _____

Any learning disabilities (diagnosed or not) _____

Occupation: _____

Medical: Any chronic medical problems or health worries? If yes, what? _____

Any medications? If yes, what? _____

Any history of? Head injury ___ Sleep problems ___ Depression ___ Panic ___ Fibromyalgia ___ ADHD ___
Chronic disorganization ___ Trouble planning ___ Severe fatigue ___ Excessive forgetfulness ___ Rage ___

Family history: Any pertinent medical and/or psychological issues? _____

Mood

Do you feel sad, or do you worry, about things *most* days? _____

Are you overwhelmed by your job, school and/or family demands *most* days? _____

Do you obsess/worry about whether you've done the right thing, what others think *most days*? _____

Do you feel tired *most days*? _____

Lifestyle

Do you exercise? _____ How often? _____

Do you live alone? _____

Do you have a circle of friends or supportive family members? _____

When you feel your best, what are you doing? _____

If you could change one thing about yourself, what would have the most impact upon your life? _____

What behavior or personality glitch sometimes gets in your way of achieving what you want? _____

Do you worry about any of your habits? e.g., procrastination, TV watching, overeating, alcohol consumption, hours on computer, hours working/not working? _____

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