History and Personal Data Questionnaire

Client Name: _____ Date: _____

Main reason for seeking counseling: _____

_____

_____

Current Problems or Symptoms

Please read each item below and determine which statement is true for you. Then, place an "**X**" in the appropriate box to indicate how often you feel the statement applies to you **during the past month**.

DURING THE PAST MONTH	NONE OR A LITTLE OF THE TIME	SOME OF THE TIME	MOST OR ALL OF THE TIME
1. Wake up at night or in the early morning and unable to return to sleep			
2. Very restless sleep			
3. Loss of energy			
4. Decreased sex drive			
5. Unable to enjoy life: Have lost a zest for life			
6. Have withdrawn from others			
7. Strong thoughts about suicide			
8. Loss of appetite			
9. Memory problems, forgetfulness, poor concentration			
10. Decreased need to sleep			
11. Increased sex drive			
12. Increased energy			
13. So happy that people describe me as "manic"			
14. Can't get to sleep			
15. Sudden episodes of nervousness or panic			
16. Fear of losing self-control			

17. Palpitations or rapid heart beat			
18. Shortness of breath			
19. Strange or unusual thoughts			
20. Hallucinations, hear voices, or see things that aren't there			
21. Very peculiar experiences			
22. Ready to explode			
23. Thoughts about harming someone			
24. Excessive use of alcohol/drugs			

Weight Loss: (How much in the past month? _____ LBS.)

Weight Gain: (How much in the past month? _____ LBS.)

Have you been trying to diet? YES NO

PREVIOUS TREATMENT FOR EMOTIONAL PROBLEMS

YEAR	PROBLEM	THERAPIST/LOCATION	HOSPITALIZATION/MEDICAL TREATMENT

ALL CURRENT MEDICATIONS	DOSAGE	SCHEDULE	DOCTOR

MEDICAL INFORMATION

Have you ever been diagnosed as having the following? **(Please circle all that apply to you.)**

HEART TROUBLE	VASCULAR (CIRCULATION) DISEASE	THYROID DISEASE
DIABETES	SEIZURE DISORDER	ULCERS
HEAD INJURY	HIGH BLOOD PRESSURE	

Child's Name: _____ Date _____

Name of person completing form and relationship to child:

_____

Please check the problems that apply to your child and place an asterisk (*) by the ones which concern you the most.

_____ Headaches

_____ Stomach problems

_____ Sleep problems

_____ Nightmares

_____ Eating problems

_____ Weight problems: gain/loss

_____ Bedwetting or soiling the bed

_____ Speech problems

_____ Temper problems

_____ School learning problems

_____ Inattention

_____ Hyperactivity

_____ Anxiety

_____ Refusal to go to school

_____ Stealing

_____ Fire setting/preoccupation with fire

_____ Fighting with other children/siblings

_____ Depression

_____ Low self-esteem

_____ Crying spells

_____ Drug or alcohol use

_____ Reaction to parental divorce or remarriage

_____ Truant from school

_____ Running away

_____ Superficially engaging or "too" charming

_____ Too friendly with strangers

_____ Little eye contact with parents

_____ Persistent nonsense questions

_____ Demanding or clingy behavior

_____ Lying

_____ Destructive

_____ Accident-prone

_____ Poor impulse control

_____ Cruelty to animals

_____ Suicidal comments, wishing to die or self-injury

_____ Other: _____