**Demographic Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Birth Sex:

 Gender Identity:

Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation:

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Is it ok to leave a voicemail? YES NO*

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Would you like to receive email communication? YES NO*

*Is it ok to send something in the mail? YES NO*

How did you hear of me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you found me online what words did you search to find me?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* *Please complete below for additional client*

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Birth Sex:

 Gender Identity:

Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sexual Orientation:

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile Phone Number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Is it ok to leave a voicemail? YES NO*

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Would you like to receive email communication? YES NO*

*Is it ok to send something in the mail? YES NO*

**PRESENTING PROBLEM:** What are the 3 biggest concerns you have right now? How long have each been going on? Put them in order of importance:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

Please check which is most true:

\_\_\_\_\_ My goals are **change-oriented**. This means I want to learn some skills to manage my circumstances and mental wellness in a more healthy way. I am motivated to make changes to my thoughts, feelings and behaviors by working on new skills inside and outside of therapy.

\_\_­­­\_\_\_ My goals are **support-oriented**. This means I want someone to listen to and validate my feelings. I need help making sense of what happens/happened, in my head, in my heart and in my life. I need someone I can trust so that I can open up and be totally authentic.

\_\_\_\_\_My goals are both change and support oriented.

\_\_\_\_\_I’m unsure and need to talk more about this.

Looking into the future, how will you know that our work and time together has been worth it? List concrete changes you will see:

What other things would you like to see change in your life (family, career, health, relationships, etc.)?

Do you foresee any obstacles to achieving your goals or the desired changes?

How long do you think therapy will need to last to achieve your goals? Write down a target date:

List 5 strengths about yourself or that others say about you, give examples of each:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anyone that you would like to be a part of your sessions or think may be helpful to be part of sessions either now or in the future?

**Career/Job, Recreation and Leisure**

What is your current occupation? How would you describe your fulfillment of your job/career?

What is your highest level of education completed and field of study?

What do you enjoy doing during your free/leisure time?

**MENTAL HEALTH HISTORY**

Provide description for problem(s) of most concern including history and age of onset:

Previous Psychiatric Dx’s including age diagnosed, by whom and outcome:

Previous Counseling including when, where, how long and with whom:

Previous and/or Current Medications/Supplements and/or Natural Remedies:

Previous and/or Current Psychiatric Hospitalizations and/or Respite Services:

**CURRENT MENTAL HEALTH**

Problems in Last 30 Days as seen by client and/or parent/guardian:

**Depressive Symptoms:**

Depressed \_\_\_\_\_\_ Feeling Helpless/Hopeless \_\_\_\_\_\_\_ Low Energy \_\_\_\_\_\_\_ Low Self-Esteem \_\_\_\_\_

Change in Appetite \_\_\_\_\_\_ Moody \_\_\_\_\_\_ Sleep Disturbance \_\_\_\_\_\_ Lost Interest in Activities \_\_\_\_\_\_

Increased Crying \_\_\_\_\_\_ Grief/Loss \_\_\_\_\_\_Isolation \_\_\_\_\_\_\_Moody \_\_\_\_\_\_\_\_\_ Trust Issues \_\_\_\_\_\_

**Intensity on Scale 1-10:**

**Manic Symptoms:**

Increased Activity \_\_\_\_\_\_\_ Easily Agitated \_\_\_\_\_\_\_ Euphoria \_\_\_\_\_\_\_ Decreased Need Sleep \_\_\_\_\_\_

Excessive Talking \_\_\_\_\_\_\_ Racing Thoughts \_\_\_\_\_\_ Talks fast \_\_\_\_\_\_\_ Distractible \_\_\_\_\_\_\_\_

**Intensity on Scale 1-10:**

**Anxious Symptoms:**

Excessive Worry \_\_\_\_\_\_ Panic Attacks \_\_\_\_\_\_ Muscle Tension \_\_\_\_\_\_ Intense Fear \_\_\_\_\_\_\_\_

Impending Danger \_\_\_\_\_\_ Feeling Tense \_\_\_\_\_\_\_ Avoidant \_\_\_\_\_\_\_\_ Low Energy \_\_\_\_\_\_\_

Anger Outbursts \_\_\_\_\_\_ Hyperactivity \_\_\_\_\_\_ Restless/On Edge \_\_\_\_\_\_ Phobia of \_\_\_\_\_\_\_\_\_\_

Intrusive Thoughts \_\_\_\_\_\_\_ Flashbacks \_\_\_\_\_\_ Nightmares \_\_\_\_\_ Easily Irritated \_\_\_\_\_\_\_

Compulsive Behaviors \_\_\_\_\_\_ Feeling Numb \_\_\_\_\_\_

**Intensity on Scale 1-10:**

**Executive Functioning: Difficulties with…**

Time Management \_\_\_\_\_\_ Organization \_\_\_\_\_ Impulse Control \_\_\_\_\_\_ Working Memory \_\_\_\_\_\_\_

Planning/Prioritization \_\_\_\_\_ Self-Monitoring \_\_\_\_\_\_ Starting or Finishing a Task \_\_\_\_\_\_\_

**Intensity on Scale 1-10:**

**Inattentive ADHD:**

Makes careless mistakes \_\_\_\_ Easily Distracted \_\_\_\_ Difficulty maintaining attention \_\_\_

Trouble listening when others are talking \_\_\_\_ Trouble with time (late/hurried/”last minute) \_\_\_\_

Difficulty following through (procrastinating) on tasks or Instructions \_\_\_\_ Restless \_\_\_\_

Difficulty staying organized \_\_\_\_ Tendency to Lose things \_\_\_\_ Forgetful \_\_\_\_ Daydreams often \_\_\_\_

Complains of being bored \_\_\_\_ Appears apathetic or unmotivated \_\_\_\_ Tired/Slow Moving \_\_\_\_

Spacy/Seems Preoccupied or lost in thought \_\_\_\_

**Intensity on Scale 1-10:**

**Hyperactive-Impulsive ADHD:**

Fidgets often \_\_\_\_ Noisy \_\_\_\_ Talks excessively \_\_\_\_ Does things without thinking/Impulsive \_\_\_\_

Interrupts often \_\_\_\_ Trouble shifting from one activity to another \_\_\_\_ Touches Everything \_\_\_\_

Choppy, sloppy handwriting \_\_\_\_ Appears to be “driven by a motor” \_\_\_\_\_ Poor Boundaries \_\_\_\_

Trouble shifting emotions and/or expressing emotions verbally or in writing \_\_­\_\_

**Intensity on Scale 1-10:**

**Anger/Conduct:**

Quick temper/rage without provocation \_\_\_\_ Short Fuse \_\_\_\_ Blaming Others \_\_\_\_\_\_ Irritable \_\_\_\_\_\_

Lying \_\_\_\_\_\_ Problems getting along with others\_\_\_\_\_\_ Fighting \_\_\_\_\_\_ Defiant \_\_\_\_\_\_\_

Argumentative \_\_\_\_\_\_\_ Explosive Anger \_\_\_\_\_\_ Difficulty managing emotions \_\_\_\_\_\_\_ Mean \_\_\_\_\_

**Intensity on Scale 1-10:**

**Other Symptoms:**

Frequent periods of déjà vu \_\_\_\_ Dark thoughts \_\_\_\_\_\_\_ Sensitive and/or Mildly paranoid \_\_\_\_\_\_\_

Frequent headaches/stomachaches \_\_\_\_\_\_\_ Memory Loss and/or forgetfulness \_\_\_\_\_\_\_

Auditory processing problems \_\_\_\_ Reading/Language problems ­­\_\_\_\_\_\_ Inflexible/Rigid \_\_\_\_\_\_

Sensitive to noise, light, clothes or touch \_\_\_\_\_\_ Insists on own way \_\_\_\_\_ Insensitive behavior \_\_\_\_

Self-Harm \_\_\_\_ Drug/Alcohol Use \_\_\_\_

**ACES SCREENING** This is your ACE Score**\_\_\_**

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you?

4. Did you often feel that … No one in your family loved you or thought you were important or special? or Your family didn’t look out for each other, feel close to each other, or support each other?

5. Did you often feel that … You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents ever separated or divorced?

7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

10. Did a household member go to prison?

**TRAUMA HISTORY**

Please state “none reported” or, if trauma occurred, please describe:

Physical Abuse:

Emotional/Verbal Abuse:

Sexual Abuse:

Witness or Victim of Domestic Violence:

Other (removal from home, impaired caregiver, traumatic loss, natural disaster, major illness, homelessness, etc…):

**Trauma Symptoms** (please check if you currently experience):

Recurrent, involuntary, and intrusive memories \_\_\_

Traumatic nightmares \_\_\_\_

Dissociative reactions (e.g., flashbacks) \_\_\_\_ Intense distress to traumatic reminder \_\_\_\_

Avoidance of trauma-related thoughts or feelings \_\_\_\_

Avoidance of external reminders (e.g., people, places, conversations, activities, objects, or situations) \_\_\_\_

Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.") \_\_\_

Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences \_\_\_

Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame) \_\_\_\_

Markedly diminished interest in (pre-traumatic) significant activities \_\_\_\_

Feeling alienated from others (e.g., detachment or estrangement) \_\_\_\_\_

Persistent inability to experience positive emotions \_\_\_\_ Irritable or aggressive behavior \_\_\_\_

Self-destructive or reckless behavior \_\_\_\_ Hypervigilance Exaggerated startle response \_\_\_\_

Problems in concentration \_\_\_\_ Sleep disturbance \_\_\_\_

OTHER:

**SUBSTANCE USE HISTORY**

Please list any prescription and/or non-prescription drugs you have used (including alcohol, caffeine and/or nicotine):

Substance Used Age of first use Last use age Frequency Amount

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Have you ever tried to quit a substance but could not (please describe):

Have you ever experienced withdrawl, DT’s, blackouts, seizures?

Have you experienced problems in relationships, school, work or with the law due to substance use?

Reason for substance use?

Family alcohol/drug abuse history:

Father ♦Mother♦grandparent(s) ♦spouse/significant other♦ stepparent/live-in♦ uncle(s)/aunt(s)♦ sibling(s) ♦ children♦ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important Questions We Must Ask**

Have you ever had suicidal ideations? If yes, please explain:

Have you ever planned to hurt yourself? If yes, please explain:

Have you ever attempted to hurt yourself? If yes, please explain:

Have you ever felt like you wanted to seriously hurt or harm someone else? If yes, please explain:

Do you have weapons in your home or access to weapons? If yes, who has access to them and what are the safety protocols around them?

Do you have currently legal issues or is the reason you are seeking therapy related to a court order? If so, please explain?

**Medical & Wellness Information**

General Health (Great, Good, Poor): Current Weight Loss or Gain:

Current Sleep (number of hours, trouble falling asleep, staying asleep):

Childhood Developmental Delays:

Prenatal/Birth/Neonatal Complications:

Childhood Illness/Hospitalizations/Surgeries/Major Accidents/Head Trauma/Allergies:

Current Medication for Physical Illness:

Past Medication for Physical Illness:

Physical Handicaps:

Primary Physician (doctor’s name, practice name, address, phone and fax number):

Date of Last Visit and for what reason:

What do you do for wellness (i.e. healthy food choices, exercise, limits on TV/electronics/work, managing stress, family time, leisure, etc.)?

How do you achieve balance in your life?

Do you have any allergies (food, environmental, medicinal, animal, etc.)

In the past year, have there been any changes in your life? (i.e.: moves, appetite, sleep, health, family, overall functioning)?

List any medications (over-the -counter & prescribed), nutritional or herbal supplements, or alternative treatments (acupuncture, chiropractic, etc.) you are taking/doing and the reasons:

**Intimate Relationships**

If you are currently in a relationship, describe your relationship:

How would you describe your communication (open/closed):

How would you describe intimacy in your relationship?

\* If you are in a relationship answer the following regarding your relationship:

1. Like \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Dislike \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Not enough of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Too much of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Ideal relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? Names and Ages:

Who currently lives in your household?

**Understanding Your Family & Influences**

Parent’s marital status: Married Divorced Never Married Separated Widowed

Describe your relationship with the following:

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Significant Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Significant Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: Age, Name and Sex:

1. Sibling 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Sibling 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Sibling 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your upbringing?

**Social Relationships**

Describe your relationship with your friends: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who would you say your support system is (people, organizations, or affiliations)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you belong to any religious or spiritual groups? YES NO

If yes, what is your level of involvement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do your religious or spiritual beliefs/practices influence your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list anything else that is important for me to know about you that would assist me in working with you to achieve your desired results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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