My Situation

Please complete the following questionnaire as completely and honestly as you can. Your answers will help in better understanding you and your situation. If you are completing this form anywhere other than our office, please remember that you are responsible for keeping the form confidential.

This form will take some time to complete, please have it completed prior to arriving for your initial appointment.

General Consent

I understand that by completing this form I am requesting services from ***Hope Restored Counseling of Florida, LLC.,*** and that the information in this form will be used to determine what services may be offered. If the therapist determines that services are not able to be provided, appropriate referrals to other professionals will be provided upon request.

If ***Hope Restored Counseling of Florida, LLC.,*** does provide services, I give them my general consent to use the information in this form. This consent does not allow for the release of any protected health care information to any other person or organization, except when mandated by law. I understand that this consent is governed by the practices described in *HIPAA Notice of Privacy* section in the Welcome Document. I have received a copy of the Welcome document. _____ **(Please initial)**

_____

Client's Name (Please print)

Presenting Problem:

(If you run out of room in any of the following sections, feel free to use the back of the page)

Primary Reason(s) you are seeking counseling:

☐ Anxiety	☐ Coping Skills	☐ Self Care Skills
☐ Assertiveness Skills	☐ Depression	☐ Other: _____
☐ Binge Eating	☐ Disordered Eating	

When did you first notice this/these problem(s)? _____

How would you rate the intensity of this/these problem(s)?

1	2	3	4	5	6	7	8	9	10
Not intense				Moderate					Extreme

What is your overall goal for counseling?

_____

_____

_____

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What seems to make the problem worse?

_____

_____

What seems to make the problem better?

_____

_____

What have you done to try to solve this problem?

_____

_____

Please check any symptoms you are currently experiencing:

__ Aggression or angry outbursts
__ Alcohol abuse
__ Anxiety
__ Avoidance of people
__ Binge eating
__ Computer addiction
__ Depression
__ Difficulty concentrating
__ Difficulty thinking
__ Distractibility
__ Dizziness
__ Drug abuse
__ Eating disorders
__ Elevated mood
__ Emotional eating
__ Fatigue
__ Fears (list)
_____
_____
_____
_____
__ Hallucinations
__ Headaches
__ Helplessness
__ Hopelessness
__ Impulsivity
__ Indecisiveness
__ Irritability
__ Loneliness
__ Memory problems
__ Mood swings
__ Muscle tension
__ Panic attacks
__ Paranoia
__ Racing thoughts
__ Restlessness or on edge
__ Sexual addiction
__ Sleeping problems
__ Stressed out
__ Stress eating
__ Suicidal thoughts
__ Trembling
__ Weight gain/loss
__ Withdrawal
__ Worrying
__ Worthlessness
__ Other Symptoms (list)
_____

Please check current stressors:

___ Conflict with children
___ Conflict with parents
___ Conflict with siblings
___ Conflict with other family
___ Emotional problems
___ Financial problems
___ Health problems
___ Housing problems
___ Job loss or change
___ Marital conflict
___ Physical problems
___ Poor peer relations
___ Problems at school
___ Problems at work
___ Recent death of friend or family
___ Recent move
___ Sexual problems
___ Separation or divorce
___ Substance abuse
___ Victims of abuse
___ Other (Please Describe):
_____
_____

What do you consider some of your strengths?

_____

_____

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What do you consider some of your weaknesses?

_____

_____

What do you enjoy doing for Leisure / Recreation? (describe interest and/or hobbies)

Activity	How Often do you participate?	Has this amount changed recently?
_____	_____	_____
_____	_____	_____
_____	_____	_____

I. Disordered Eating Habits: Complete this section only if you are seeking counseling for disordered eating habits (binge eating, emotional eating, stress eating) or feel that it is relevant to your situation.

Questions about Eating	No	Yes
Would you say that you eat when you are stressed, bored, and/or emotional?	☐	☐
Have you every "lost control" and ate a large amount of food even though you were full?	☐	☐
Do you often eat, within any 2-hour period, what most would consider an unusually **large** amount of food?	☐	☐
If you checked **NO**, skip to the next section		
Has this been as often, on average, as twice a week for the last 3 months?	☐	☐
In the **last 3 months** have you often done any of the following to avoid gaining weight?		
Made yourself vomit?	☐	☐
Took more than twice the recommended dose of laxatives?	☐	☐
Fasted – not eaten anything at all for at least 24 hours?	☐	☐
Exercised for more than an hour specifically to avoid gaining weight after you've binge ate?	☐	☐
If you checked "Yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	

Describe any of your disordered eating habits not asked about in the above section:

_____

_____

When did you notice that these habits were of concern? _____

Why are you seeking counseling now for these habits?

_____

_____

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What have you done in the past to change your disordered eating habits?

_____

_____

Would you consider yourself obsessed over your weight? ☐ Yes ☐ No

How often a week are you active? _____

What do you enjoy doing for activity? _____

II. Mental Health:

Risk Assessment	Past (when)	Now Yes or No
Have you ever had thoughts of hurting yourself?		☐ Yes ☐ No
Have you ever had thoughts of committing suicide?		☐ Yes ☐ No
Have you ever had a plan to commit suicide?		☐ Yes ☐ No
Have you made threats to kill yourself?		☐ Yes ☐ No
Have you ever made a suicide attempt?		☐ Yes ☐ No
Have you ever mutilated yourself?		☐ Yes ☐ No
Have you ever had thoughts of harming someone?		☐ Yes ☐ No
Have you ever had plans to harm someone?		☐ Yes ☐ No
Have you made threats to harm someone?		☐ Yes ☐ No
Have you ever attempted to harm someone?		☐ Yes ☐ No
Have you every been threatened or hurt by someone else?		☐ Yes ☐ No

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not bothered at all	Bothered several days	Bothered more than half the days	Bothered nearly every day
Little interest or pleasure in doing things, especially things you used to enjoy?	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you are a failure or have let yourself or family down	☐	☐	☐	☐
Trouble concentrating on things, such as at work or in completing a task or project?	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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Questions about anxiety	No	Yes
In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic	☐	☐
If you checked **NO**, skip to the next section		
Has this ever happened before?	☐	☐
Have previous attacks come on suddenly, that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
Do these attacks brother you a lot or are you worried about having another attack?	☐	☐
Thinking about your bad intense anxiety attack, please answer the following questions		
Were you short of breath?	☐	☐
Did your heart race, pound, or skip?	☐	☐
Did you have chest pain or pressure?	☐	☐
Did you sweat?	☐	☐
Did you feel as if you were choking?	☐	☐
Did you have hot flashes or chills?	☐	☐
Did you feel nauseous or have an upset stomach, or feel like you were doing to have diarrhea?	☐	☐
Did you feel dizzy, unsteady, or faint?	☐	☐
Did you have tingling or numbness in parts of your body?	☐	☐
Did you tremble or shake?	☐	☐
Were you afraid you were dying?	☐	☐

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not bothered at all**	**Bothered several days**	**Bothered more than half the days**	**Bothered nearly every day**
Feeling nervous, anxious, on edge, or worrying a lot about different things?	☐	☐	☐	☐
If you checked **NO**, skip to the next section				
Feeling so restless that it is hard to sit still?	☐	☐	☐	☐
Getting tired very easily?	☐	☐	☐	☐
Experience muscle tension, aches, or soreness?	☐	☐	☐	☐
Have trouble falling asleep or staying asleep?	☐	☐	☐	☐
Becoming easily annoyed or irritated?	☐	☐	☐	☐

Describe any treatment you have tried for your current problem(s) or other problems you've experienced:

Type	When (Start-Finish)	Where	Presenting Problem(s)
Outpatient Counseling			

Medication Management			
Psychiatric Hospitalization			
Drug/Alcohol Treatment			
Self-Help/Support Groups			
Other (Describe): _____ _____			

Please check any substance use/abuse:

Substance	Past Use	Use Now	Amount Used	Frequency	Date Last Used
Tobacco					
Caffeine					
Alcohol					
Marijuana					
Cocaine/Crack					
Heroin					
Amphetamines					
LSD					
Ecstasy					
Inhalants					
Prescription Drugs					
Other Drugs (please list)					

III. Medical History:

How would you rate your overall health?

☐ Very Good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

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Date of last doctor visit: _____ Date of last physical: _____

How important is your overall health to you?

☐ Important all the time ☐ Important some of the time ☐ Not important overall

How would you rate your current sleep habit?

☐ Very Good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

Check which of the following you have experienced:

__ Arthritis (Onset_____)
__ Asthma (Onset_____)
__ Cancer (Onset_____)
__ Chronic pain (Onset_____)
__ Diabetes (Onset_____)
__ Head injury/concussion (when_____)
__ Headaches (Onset_____)
__ Heart disease (Onset_____)
__ Hepatitis (Onset_____)
__ HIV (Onset_____)
__ Hypertension (Onset_____)
__ Hypoglycemia (Onset_____)
__ High fevers (Onset_____)
__ Kidney disease (Onset____)
__ Liver disease (Onset_____)
__ Loss of consciousness (When_____)
__ Lung disease (Onset_____)
__ Meningitis (Onset_____)
__ Migraines (Onset_____)
__ Pregnancy (# of _____)
__ Seizures (Onset_____)
__ Sexually transmitted Disease (Onset_____)
__ TB (Onset_____)
__ Thyroid problems (Onset_____)
__ Other (list)
_____
_____

Any additional information about any of the above medical conditions?

_____

_____

List any hospitalizations or surgeries you have had:

_____

_____

Please list all current medications, prescribed and over-the-counter, including herbal supplements.

Medication	Dosage	Date started	Prescribed by	Condition Prescribed for

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Do you have any allergies? (Food or drug) If yes, please list

_____

IV. Social History:

Place of birth: _____

Where did you grow up? _____

Did your family move around a lot? ☐ Yes ☐ No

If yes, please describe: (how often, etc.)

_____

How many siblings do you have? _____

Were you raised by someone other than your biological parent(s)? ☐ No ☐ Yes

If yes, who raised you? _____

Which family member(s) are you close to?

_____

Briefly describe your childhood:

_____

_____

_____

Have your experienced any trauma? ☐ No ☐ Yes

If yes, what type (sexual, physical, emotional, neglect)?_____

Who inflicted this trauma on you? _____

Describe your relationship with your **father** when you were a child:

_____

Describe your current relationship with your father:

_____

Describe your relationship with your **mother** when you were a child:

_____

Describe your current relationship with your mother:

_____

Please describe any significant conflicts you have / had with family members:

_____

Whom or what do you rely on for emotional support?

_____

Do you consider those individuals listed above to be your support system? ☐ Yes ☐ No

List any biological family members that have mental health problems. Who (relationship to you)?	What problem (s) did they experience?	Did they seek treatment for this / these problems?

V. Spiritual / Religious:

How important are spiritual matters to you? ☐ Not at all ☐ Somewhat ☐ Moderately ☐ Very much

Are you affiliated with a spiritual or religious group? ☐ No ☐ Yes, please describe _____

Were you raised within a spiritual or religious group? ☐ No ☐ Yes, please describe _____

_____

VI. Relationship History:

In the past, how would you rate the quality of your peer relationships?

☐ Very Good ☐ Good ☐ Satisfactory ☐ Unsatisfactory ☐ Poor

Do you make friends easily? ☐ Yes ☐ No

If no, describe why you think you do not:

_____

_____

What is your sexual orientation? (Optional)_____

What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other, _____

Describe your current relationship, including any stressors:

_____

_____

Describe any prior marriages or long-term relationships and the reasons for the divorce/breakup:

_____

_____

If you have children, list their names and ages:

_____

Who currently lives with you:

_____

What problems (if any) do you have with your children?

_____

VII. Educational History:

What is the highest grade you completed? _____

What kind of student were you? _____

If you received any special educational services, describe them:

_____

How did you get along with your teachers and peers?

_____

Did you have any discipline problems in school?

_____

VIII. Occupational History:

Are you currently employed? ☐ Yes ☐ No ☐ Disabled ☐ Student ☐ Other, _____

If yes, what type of work do you do? _____

What do you like about your job?

_____

What do you not like about your job?

_____

What job stressors (if any) are you experiencing?

_____

How do you get along with your work colleagues?

_____

If you have ever been laid off or fired, please describe:

_____

IX. Military History:

If you served in the military, what branch did you serve in and when?

_____

If you served in combat or other high-risk zones, please describe:

_____

_____

If you were discharged, what type of discharge did you have?

_____

X. Legal History:

Have you been court-ordered, now or in the past, to receive therapy? ☐ No ☐ Yes

If yes, please describe _____

List any current involvement you have with the criminal or civil legal system:

_____

_____

Is there any additional information that would be helpful for your therapist to know?

_____

_____

_____

Thank you so much for your time and thoughtfulness in completing this questionnaire.

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