PRE-COUNSELING QUESTIONNAIRE

ReSource Counseling Center, LLC

This questionnaire is intended to provide information that will assist your counselor in understanding you and your needs. Please complete it carefully. All information furnished will be kept confidential.

I. PERSONAL INFORMATION

Name_____ Birth Date _____

Address _____City _____ State _____

Employer _____Occupation _____Highest Education _____

Cell Phone _____ Work Phone _____ Land Line _____

II. FAMILY HISTORY

A) Briefly describe the atmosphere and relationships you experienced during your childhood. Information about closeness to the family, who exerted authority, the roles of religion, the extended family, education, and health will be helpful.

B) Please list the names and ages of your parents. Include step-parents, also. If any have died, please record the year of death and the person's age at death.

C) Please list the names and ages of brothers and sister. If any have died, please record the year of death and the person's age at death.

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D) If married, please give the name and age of your spouse and the date of your marriage. If you have been married before, please write the names of your former spouses(s) and the date(s) of that (those) marriage(s).

E) Briefly describe your marital relationship(s).

F) Please give the names and ages of all children and stepchildren, whether or not they are living at home.

In the following three questions, the term "family" refers to extended family including parents, step-parents, brothers, sisters, aunts, uncles, and children.

G) Do you or anyone in your family have a history of depression or other mental illness? Were any ever hospitalized for this?

H) Have you or any member of your family ever attempted suicide? If so, who and when?

I) Have you or any member of your family ever had a problem of misusing alcohol or drugs? Who and for how long? Is there a current problem?

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III. EDUCATIONAL AND WORK HISTORY

A. How well did you do in school?

B. What jobs have you held previous to the current one?

IV. MEDICAL HISTORY

A. List any recurrent illnesses such as allergies, diabetes, asthma, high blood pressure, high cholesterol, epilepsy, heart conditions, chronic obstructive pulmonary disease, sleep apnea, etc.

B. List all medications you are currently taking.

C. What other treatments have you received (physical or occupational therapy, C-PAP, dietary restrictions, etc.)?

V. COUNSELING CONCERNS

A. Through what person or agency did you hear about our services?

C. What are your major concerns or problems?

D. Please list the names of counselors, psychologists, physicians, psychiatrists or pastors with whom you have sought help in the past. Please also write the year in which you worked with each person.

D. What goals do you hope to accomplish as a result of our working together?

VI. CURRENT PROBLEMS

Below is a list of frequently reported problems and complaints. Please indicate the extent to which any of these problems has affected you during the past two weeks by scoring each item according to its degree of severity (0=none, 1=mild, 2=moderate, 3=severe).

1. ____ Feeling blue
2. ____ Feeling lonely
3. ____ Low motivation to get things done.
4. ____ Issues with eating
5. ____ Difficulty making decisions
6. ____ Trouble concentrating
7. ____ Restlessness or excessive energy
8. ____ Fatigue
9. ____ Worry
10. ____ Trouble falling asleep
11. ____ Awaking during the night with problems returning to sleep
12. ____ Awaking 1-2 hours before rising and remaining awake
13. ____ Tension in shoulders, neck or chest
14. ____ Stomach discomfort
15. ____ Spells of panic
16. ____ Rapid, shallow breathing
17. ____ Thoughts of ending your life
18. ____ Troubled by Internet usage
19. ____ Irritability
20. ____ Temper outbursts you cannot control
21. ____ Feeling guilty
22. ____ Feeling hopeless
23. ____ Feeling worthless
24. ____ Loss of interest in things, people or activities
25. ____ Thinking you are superior to other people
26. ____ Feeling you are watched or talked about by others
27. ____ Seeing or hearing things of which others are unaware
28. ____ The idea that something is wrong with your mind
29. ____ Sexual concerns
30. ____ Body discomfort