INSIDEOUT DYNAMICS
CURE Counseling & Assessment Centre

130 Governors Square #A, Fayetteville, GA 30215 Phone: (678) 364.1300 Fax: (678) 364-1352
Email: IODsms@bellsouth.net Web: www.insideoutdynamics.com
Email: office@cure-international.org Web: www.cure-international.org

Dear New Client/s,

Attached is an Intake and other forms that are absolutely essential for us to serve you. The exchange of information is what allows us to understand and process needed data that helps us make better clinical decisions and diagnoses.

Furthermore, a complete Intake Form also speeds up the counseling process and is a more effective use of the clients and therapists time. The securing of this information can save you money because less time is needed to gather this information during the initial sessions. Also, please review the following information, sign and return to the Counseling Center. We look forward to serving you! Thank you for considering us. We will do our best to aid and assist you during the counseling process and strive to provide you with the best possible service. Please bring the completed forms to your first session. Your cooperation is greatly appreciated.

Sincerely,

The InsideOut Dynamics & CURE Counseling Teams

Client Registration

(Please Print)

Client(s) Name: Today's Date:_____/_____/2006

(First) (Middle) (Last)

Sex: Male__ Female__ Age:__Date of Birth:___/___/_____ SSN:_____-_____-_____

Insurance Member:_____

Home Address:_____

City:_____

State:_____ Zip:_____

Preferred Method of Contact: Circle All That Apply
Home Phone: ( ) - Work phone: ( ) -
Cell Phone: ( ) - Email:_____

Education: Current Student Yes No Name School_____

Grade: _____ Last Grade or Degree Earned:_____

Marital Status (Circle One): Single Married Separated Divorced Cohabiting

Family Physician: _____ Office Location:_____

Referred By:_____

Person to Contact in Emergency:_____ Phone: ( ) -
(If different than above)

Confidentiality Statement:
All sessions are confidential and patient information is treated as confidential ***except*** under the following circumstances:

1) The patient has waived her/his right to confidentiality.
2) Identifying information is adequately disguised or removed.
3) A breach is required by law.

* If you have any questions about patient confidentiality please discuss them with your therapist.

Signed:_____

Today's Date:_____/_____/2006

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INSIDEOUT DYNAMICS/CURE COUNSELING & ASSESSMENT CENTRE MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

InsideOut Dynamics (IOD) is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by IOD or received by IOD from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. IOD will abide by the terms of this Notice or the Notice currently in effect at the time of the use or disclosure of your protected health information.

IOD reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information Not Requiring Your Consent

IOD may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes or home health agencies.

For example, IOD may determine that you require the services of a specialist. In referring you to another doctor, IOD may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by IOD to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, IOD will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination
- Conducting or arranging for medical review, legal services and auditing functions.

For example, IOD may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or access the effectiveness of your treatment when compared to patients in similar situations.

IOD may contact you, by telephone, mail or email, to provide appointment reminders and missed appointment notifications. You must notify us if you do not wish to receive appointment and missed appointment notifications.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when IOD is permitted or required to use or disclose your protected health information without your consent or authorization. **Examples include the following**:

As permitted or required by law. In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of crime. Mental Health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

For public health activities. We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authorities authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV tests results to other providers or persons when there has been or will be risk of exposure.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of InsideOut Dynamics notice of privacy practices. This notice describes how InsideOut Dynamics may use and disclose my health information, certain restrictions on the use and disclosure of my healthcare information and the rights that I have regarding my protected health information.

_____ _____/_____/_____

(Signature of Patient or Personal Representative) (Date)

_____

(Relationship to Patient)

_____ _____/_____/_____

(Witness) (Date)

LINDA WEIGAND M.A., NCC, Licensed Professional Counselor, AACA
Ms. Weigand has been a licensed professional counselor for almost a decade. She has a Masters Degree in Professional Counseling and has worked in extremely diverse counseling settings. Ms. Weigand is the owner of INSIDEOUT DYNAMICS.

C. STEVEN SHAFFER, D. Min.
Degrees: B.A., M.A. in Education, M.S. in Professional Counseling, D. Min. in Biblical Literature.

Dr. C. Steven Shaffer is a Licensed Associate Professional Counselor. However, when functioning as a therapist, he ***is not*** functioning in his doctoral capacity, as his Doctorate is in Biblical Literature. Furthermore, he has been counseling people in a variety of settings for over 25 years and is a member of the American Association of Christian Counselors, a Nationally Certified Counselor and a Licensed Associate Professional Counselor with the State of Georgia. Steve completed his internship at Ft. McPherson Army Base in Atlanta and did additional work in the Army Substance Abuse Program and has worked in multiple counseling settings.

Steve functions as a “Life Coaching,” relationship building, marriage counseling, anxiety and depression, temperament assessments and life and social skills. He is known as a relationship specialist.

Vernon Rossin & Naomi Duncan

InsideOut Dynamics Financial Policy

Rev. 8/06

Please read and sign our Financial Policy, demonstrating your acceptance of the terms. By signing below, I/we certify that I/we have read and understand all of the agreement, understand all of its obligations, and enter into it freely.

Signature of Client/Responsible Party:_____

Date_____/_____/20____ Witness Date _____/_____/20_____

ALL CLIENTS

- Our fee is **$125 per session** (45-50 min.). Payment from cash clients is due at the time of service.
- We accept cash, check, Visa, or Master Card.
- A $30 fee is charged for all checks returned from the bank for any reason.
- An annual $25 administrative fee is charged at the first visit.
- A billing statement or receipt is generated only upon request.
- In order to maintain standing appointments, your account must be kept current.

MISSED APPOINTMENTS

- Please help us serve you more efficiently by keeping your scheduled appointments!
- Although a courtesy call is generated as a reminder the day before your scheduled appointment, it is your responsibility to keep track of the appointments you schedule. Not receiving a confirmation call is not an excuse for missing an appointment, and the courtesy call is not an opportunity to cancel your appointment.
- Unless cancelled **48 hours in advance** of your appointment time you will be charged a missed appointment fee of $75 due prior to or on your next visit.

CLIENTS UTILIZING INSURANCE

- Clients who carry insurance should remember that professional services are rendered and charged to the client and not to the insurance company.
- InsideOut Dynamics currently accepts assignment of most insurance benefits.
- You are responsible to obtain benefit information and pre-certification, if required.
- Co-payments and fees are due and **payable at the time of your visit**.
- We will allow 45 days for remittance of insurance benefits.
- If we do not receive payment from your insurance company within this time frame, **you will be held responsible for the balance due.**
- It will then become your responsibility to clear your account with us and then collect monies due you from your insurance company.
- We cannot accept responsibility for collecting your insurance claim or negotiating a dispute.

COURT/COURT FEES/AFFIDAVITS

- During the course of the counseling process it may be necessary to request documented information from your therapist for Attorneys, Human Resources Managers, Corrections Officers, Courts, etc. Our practice guidelines are to provide a notarized affidavit for a cost of $75.00 to the client. Affidavits are legal documents used in court in the therapist's sted. In the event the therapist is subpoenaed to court, the client agrees to pay **$125.00/hour for each hour** the therapist is out of the office, with a **minimum of two hours to be paid prior to court**. Payment is the responsibility of the client, as insurance companies do not cover court costs or loss of income for the therapist. The **balance is due within 7 days after the hearing.** Fees will be charged to your credit card on file unless other arrangements have been made.

CLIENTS WHO ARE MINORS

- The adult accompanying a minor or the parent/guardian(s) is responsible for full payment.
- Minors unaccompanied by an adult will be denied services (except in an emergency) unless payment has been pre-arranged.
- In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state of Georgia.

Thank You!

Sandy Shaffer, Practice Administrator

Debit/Credit Card on File: (Please check the appropriate card) **(Required)**

MasterCard___ Visa____ Expiration Date:_____/_____/_____

Card Number_____-_____-_____

Name as it Appears on Card: _____

Signature:_____ Date: _____/_____/_____

Insurance Information: *(A copy of the Insurance Card (Front & Back is preferred).*

Name of Company:_____

Address:_____

City:_____ State:_____ Zip:_____

Policy Number:_____

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- A breach is required by law.

* If you have any questions abut patient confidentiality please discuss them with your therapist.

Release of Information:
At times, information may be requested from our office. In order to expedite your request, a signed Consent for Release of Information form must be on file prior to the release of any information from our office. Request forms are available online at www.insideoutdynamics.com. Signed forms may be scanned and emailed (preferred method), mailed or faxed.

Life-History Questionnaire

Name:_____

"Essential Life-Building Tools"

Linda Weigand, Licensed Therapist

C. Steven Shaffer, Licensed Therapist

Vernon Rossin, Licensed Therapist

Naomi Duncan, Licensed Therapist

Purpose of This Questionnaire:
The purpose of this questionnaire is to obtain a comprehensive picture of your background. In psychotherapy, records are necessary, since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time. It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are strictly confidential. **NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORD WITHOUT YOUR PERMISSION.**

If you do not desire to answer any questions, merely write "Do Not Care to Answer."

Age: ___ Gender: Male Female (Circle One)

Chief Complaint/Reason for Coming:

PLEASE LIST ANY RELEVANT FAMILY MEDICAL/PSYCHIATRIC HISTORY:

MEDICAL HISTORY/NUTRITION/ALLERGIES/PAIN:
Circle **Bold Faced** Areas & Mark True of False

T or F -- I rarely uses over the counter medications and/or supplements.

T or F -- There is no medication or medical treatment that pertains to the current chief complaint.

My nutrition is **(poor, average, good)** and generally consists of **(1, 2 or 3)** meals/snacks per day. I pay **(little, average, close)** attention to food groups and dietary recommendations, caffeine use is **(low, average high),** and sugar use is **(low, average high).** I pay **(little, average, close)** attention to water intake, which amounts to approximately _____ ounces per day. My experience of pain (____/10).

ACTIVITIES/INTERESTS/TIME-STRUCTURING: My typical day consists of rising around _____ and going to _____. After returning home for the day, I typically _____. Weekends/days off generally are spent _____. Recreational and leisure activities are, for the most part **(normal, not normal)** for me. Overall, my lifestyle is (normal, not normal, changed vastly in the past few months).

EDUCATION/CAREER/LEARNING NEEDS: (Circle what applies)
I have completed**: HIGH SCHOOL SOME COLLEGE COLLEGE MASTERS PROGRAM DOCTORATE** and experienced **SOME LITTLE** difficulty with schoolwork.

I have generally worked in the _____ field. I currently work at _____.

Work has been reasonably satisfying: **(YES NO SOMETIMES)**

Making and managing money has been: (**EASY HARD VERY DIFFICULT**)
Current financial condition is: **(VERY POOR FAIR GOOD REAL GOOD)**

LEGAL HISTORY/BEHAVIORAL PROBLEMS/SUBSTANCE ABUSE/LIABILITIES: There are no significant liabilities likely to deter me from resolving my presenting difficulties. **(Yes No)**

If yes, what?_____

difficulties? If so please explain:

_____
_____

List any clear obstacles to your recovery (if any):

_____
_____

If you have a legal history or criminal back history please list below:

_____
_____

Substance abuse history (if applicable):

_____
_____

If you smoke, how much do you smoke? _____.

Do you consider yourself overweight? Should weight management be a part of your therapy?
YES NO.

FAITH/IMPORTANT BELIEFS/CULTURE/ASSETS: Assets likely to benefit my resolution of my presenting difficulties include (**physical health, maturity, faith, exercise, prior successes in life** and _____). Cultural/socioeconomic background was **(low, average, high).**

FAMILY HISTORY/INTEPERSONAL FUNCTIONING/SOCIAL SUPPORTS:
I grew up in a SINGLE, BLENDED, or NUCLEAR (original mom & dad) family headed by my _____.

The atmosphere was:

_____

Caregivers were generally:

_____

Abuse/neglect **(WAS WAS NOT)** a part of the my developmental history. If yes, it consisted of:

_____
_____

There was undesired sexual contact around the age of _____, and I have experienced _____ as a result of that activity.

During childhood I:
_____
_____

During adolescence I:
_____
_____

By adulthood I:
_____
_____

Currently I have a **(NO LIMITED LARGE)** social support system that includes
_____

If married, marital satisfaction was rated as _____/10.

Sexual life is (**NON EXISTENT, POOR, AVERAGE, GOOD**)

Sleep/Neurovegative Signs of Depression:
I typically sleep about _____ hours per night. There are **(NO SOME)** problems with getting to sleep, maintaining sleep, or early awakening, with the result that I typically awaken feeling (**VERY TIRED TIRED SOMEWHAT RESTED RESTED**).

I tend to have **(LOW MEDIUM HIGH)** energy, (**LIMITED HIGH** concentration and attention to daily activity, **LOW AVERAGE HIGH** appetite, and **LOW AVERAGE HIGH)** interest in sex or other formerly pleasurable activities. This overview as presented is (**NORMAL NOT NORMAL**) over the past few weeks/months.

Date: _____

1. General Information:

By whom were you referred? _____

Marital Status: (circle one): Single Engaged Married Separated Divorced Widowed

Remarried: (How many times? _____ Living with someone? _____

Do you live in (circle one): house hotel room apartment other

2. Description of Presenting Problems:

State in your own words the nature of your main problems_____

_____

_____

_____

_____

_____

_____

On the scale below please estimate the severity of your problem(s):

Mildly Upsetting____	Moderately Upsetting____	Very Severe____	Extremely Severe____	Totally Incapacitating____

When did your problems begin (give dates): _____
_____
_____
_____
_____

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of your problems: _____
_____
_____
_____

What solutions to your problems have been most helpful? _____
_____
_____

Have you been in therapy before or received any prior professional assistance for your problems? If so, please give name(s), professional title(s), dates of treatments and results: _____
_____
_____
_____
_____

3. <u>Personal and Social History</u>:

(a) Date of Birth _____ Place of Birth _____

(b) <u>Siblings</u>: Number of Brothers: _____ Brothers' ages: _____
Number of Sisters: _____ Sisters' ages: _____

(c) <u>Father</u>: Living? _____ If alive, give father's present age: _____
Occupation: _____
How is his health? _____
Deceased? _____ If deceased, give his age at time of death: _____
How old were you at the time? _____ Cause of death: _____
_____

(d) <u>Mother</u>: Living? _____ If alive, give mother's present age: _____
Occupation: _____
How is her health? _____
Deceased? _____ If deceased, give her age at time of death: _____
How old were you at the time? _____ Cause of death: _____
_____

(e) <u>Religion</u>: As a child: _____ As an adult: _____

(f) <u>Education</u>: What is the last grade you completed? _____ Degree(s)? _____

(g) <u>Scholastic Strengths and Weaknesses</u>: _____
_____

(h) <u>Underline any of the following that applied during your childhood/adolescence</u>:

Happy Childhood	School Problems	Medical Problems
Unhappy Childhood	Family Problems	Alcohol Abuse
Emotional/Behavior Problems	Strong Religious Convictions	Legal Trouble
Drug Abuse	Others:_____	

(i) What sort of work are you doing now? _____

(j) What kinds of jobs have you held in the past? _____
_____

(k) Does your present work satisfy you? _____ If not, please explain why: _____
_____
_____

(l) What is your annual family income? _____ How much does it cost you to live? _____

(m) What were your past ambitions? _____
_____

(n) What are your current ambitions? _____
_____

(o) What is your height? ___ ft. ___ inches What is your weight? _____lbs.

(p) Have you ever been hospitalized for psychological problems? Yes ____ No ____ If yes, when and where? _____

(q) Do you have a family physician? Yes ____ No ____ If yes, please give his/her name(s) and telephone number(s)
_____
_____

(r) Have you ever attempted suicide? Yes ____ No ____

(s) Does any member of your family suffer from alcoholism, epilepsy, depression or anything else that might be considered a "mental disorder"?

Circle those that apply: Mother Father Grandparent Aunt Uncle Sibling

(t) Has any relative attempted or committed suicide? _____

(u) Has any relative had serious problems with the "law"? _____

MODALITY ANALYSIS OF CURRENT PROBLEMS/CHALLENGES

The following section is designed to help you describe your current problems in greater detail and to identify problems, which might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven (7) modalities of *Behavior, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships and Biological Factors*.

4. Behavior:
Underline any of the following behaviors that apply to you:

Overeating	Suicidal attempts	Cannot keep a job
Take drugs	Compulsions	Insomnia
Vomiting	Smoke	Take too many risks
Odd behavior	Withdrawal	Lazy
Drink too much	Nervous tics	Eating problems
Work too hard	Concentration difficulties	Aggressive behavior
Procrastination	Sleep disturbance	Crying
Impulsive reactions	Phobic avoidance	Outbursts of temper
Loss of control		

Are there any specific behaviors, actions or habits that you would like to change? Yes _____
No ____ If so, what are they? _____

_____

What are some special talents or skills that you feel proud of? _____

_____

What would you like to do more of? _____

What would you like to do less of? _____

What would you like to start doing? _____

What would you like to stop doing? _____

How is your free time spent? _____

_____

Do you keep yourself compulsively busy doing an endless list of chores or meaningless

activities? Yes ____ No ____ If so, what do you do?_____

_____

Do you practice relaxation or meditation regularly? Yes ____ No ____

5. <u>Feelings</u>:
<u>Underline any of the following feelings that often apply to you</u>:

Angry	Guilty	Unhappy
Annoyed	Happy	Bored
Sad	Conflicted	Restless
Depressed	Regretful	Lonely
Anxious	Hopeless	Contented
Fearful	Hopeful	Excited
Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense
Envious	Jealous	Others:

<u>List your five main fears</u>:

1. _____
2. _____
3. _____
4. _____
5. _____

What feelings would you most like to experience more often? _____

_____

What feelings would you like to experience less often? _____

_____

What are some positive feelings you have experienced recently? _____

_____

When are you most likely to lose control of your feelings? _____

_____

Describe any situations that make you fell calm or relaxed: _____

_____

Please complete the following:

If I told you what I'm feeling now _____

One of the things I feel proud of is _____

One of the things I feel guilty about is _____

I am happiest when _____

One of the things that saddens me the most is _____

_____

If I weren't afraid to be myself, I might _____

I get so angry when _____

If I get angry with you _____

What kind of hobbies or leisure activities do you enjoy or find relaxing? _____

_____

Do you have trouble relaxing and enjoying weekends and vacations? Yes ____ No ____

If yes, please explain: _____

_____

6. Physical Sensations:
Underline any of the following that often apply to you:

Headaches	Stomach trouble	Skin problems
Dizziness	Tics	Dry mouth
Palpitations	Fatigue	Burning or itchy skin
Muscle spasms	Twitches	Chest pains
Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Don't like being touched
Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating
Tingling	Watery eyes	Visual disturbances
Numbness	Flushes	Hearing problems

Menstrual History: (if applicable)
Age of first period: _____ Were you informed or did it come as a shock? _____
Are you regular? _____ Date of last period? _____
Duration? _____Do you have pain with your period? _____
Do your periods affect your mood? _____

What sensations are especially:

Pleasant for you? _____

_____

Unpleasant for you? _____

_____

7. Images:
Underline any of the following that apply to you. **Do you have**:

Pleasant sexual images	Unpleasant sexual images
Unpleasant childhood images	Lonely images
Helpless images	Seduction images
Aggressive images	Images of being loved

Check which of the following that applies to you. **I picture myself**:

being hurt	hurting others
not coping	being in charge
succeeding	failing
losing control	being trapped
being followed	being laughed at
being talked about	being promiscuous
others: _____	

What picture comes into your mind most often? _____

_____

Describe a very pleasant image, mental picture or fantasy. _____

_____

Describe a very unpleasant image, mental picture or fantasy. _____

_____

Describe your image of a completely "safe place". _____

_____

How often do you have nightmares? _____

8. Thoughts:

Underline each of the following thoughts that apply to you:
I am worthless, a nobody, useless and/or unlovable.
I am unattractive, incompetent, stupid and /or undesirable.
I am evil, crazy, degenerate and /or deviant.
Life is empty, a waste; there is nothing to look forward to.
I make too many mistakes, cant' do anything right.

Underline each of the following words that you might use to describe yourself:
Intelligent, confident, worthwhile, ambitious, sensitive, loyal, trustworthy, full of regrets, worthless, a nobody, useless, evil, crazy, morally degenerate, considerate, a deviant, unattractive, unlovable, inadequate, confused, ugly, stupid, naïve, honest, incompetent, horrible thoughts, conflicted, concentration difficulties, memory problems, attractive, can't make decisions, suicidal ideas, persevering, good sense of humor, hard-working.

What do you consider to be your most irrational thought or idea? _____

_____

Are you bothered by thoughts that occur over and over again? _____

On each of the following items, please circle the number that most accurately reflects your opinions:

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
I should not make mistakes.	1	2	3	4	5
I should be good at everything I do.	1	2	3	4	5
When I do not know, I should pretend that I do.	1	2	3	4	5
I should not disclose personal information.	1	2	3	4	5
I am a victim of circumstances.	1	2	3	4	5
My life is controlled by outside forces.	1	2	3	4	5
Other people are happier than I am.	1	2	3	4	5
It is very important to please other people.	1	2	3	4	5
Play it safe; don't take any risks.	1	2	3	4	5
I don't deserve to be happy.	1	2	3	4	5
If I ignore my problems, they will disappear.	1	2	3	4	5
It is my responsibility to make others happy.	1	2	3	4	5
I should strive for perfection.	1	2	3	4	5
Basically, there are two ways of doing things- the right way and the wrong way.	1	2	3	4	5

Expectations regarding therapy:

In a few words, what do you think therapy is all about? _____

_____

How long do you think your therapy should last? _____

How do you think a therapist should interact with his or her clients? _____

_____

What personal qualities do you think the ideal therapist should possess? _____

_____

Please complete the following:
I am a person who _____
All my life _____
Ever since I was a child _____
It's hard for me to admit _____
One of the things I can't forgive is _____
A good thing about having problems is _____
The bad thing about growing up is _____
One of the ways I could help myself but don't is _____

9. Interpersonal Relationships:

A. Family of Origin:
(1) If you were not brought up by your parents, who raised you and between what years?
_____

(2) Give a description of your father's (or father substitute's) personality and his attitude towards you (past and present): _____
_____

(3) Give a description of your mother's (or mother substitute's) personality and her attitude toward you (past and present): _____

_____

(4) In what ways were you disciplined (punished) by your parents as a child? _____

_____

(5) Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and between children. _____

_____

(6) Were you able to confide in your parents? _____

(7) Did your parents understand you? _____

(8) Basically, did you feel loved and respected by your parents? _____

(9) If you have a step-parent, give your age when parent remarried. _____

(10) Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc?

---

(11) Who are the most important people in your life? _____

B. Friendships:

(1) Do you make friends easily? _____

(2) Do you keep them?
_____

(3) Were you ever bullied or severely teased? _____

(4) Describe any relationship that gives you:

- Joy: _____

- Grief: _____

(5) Rate the degree to which you generally feel comfortable and relaxed in social situations: Very relaxed ____ Relatively comfortable ____ Relatively uncomfortable ____ Very anxious ____

(6) Generally, do you express your feelings, opinions and wishes to others in an open, appropriate manner? _____ Describe those individuals with whom (or those situations in which) you have trouble asserting yourself? _____
_____
_____

(7) Did you date much during High School? _____ College? _____
(8) Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings? _____

C. Marriage:
(1) How long did you know your spouse before your engagement? _____
(2) How long have you been married? _____
(3) What is your spouse's age? _____
(4) What is your spouse's occupation? _____
(5) Describe your spouse's personality. _____
(6) In what areas are you compatible? _____
(7) In what areas are you incompatible? _____
(8) How do you get along with your in-laws (this includes brothers and sister-in-law)? ____
_____
(9) How many children do you have? _____ Please give their names, ages and sexes:
_____
_____
_____
_____
(10) Do any of your children present special problems? _____
(11) Any relevant information regarding abortions or miscarriages? _____
_____

D. Sexual Relationships:
(1) Describe your parents' attitude toward sex. Was sex discussed at home? _____
_____
(2) When and how did you derive your first knowledge of sex? _____
_____
(3) When did you first become aware of your own sexual impulses? _____
(4) Have you ever experienced any anxiety or guilt feelings arising out of sex or masturbation? If yes, please explain.
_____
_____
(5) Any relevant details regarding your first or subsequent sexual experiences? _____
_____
(6) Is your present sex life satisfactory? If not, please explain. _____
_____
_____
(7) Provide information about any significant homosexual reactions or relationships. _____
_____

E. Other Relationships:
(1) Are there any problems in your relationships with people at work? If so, please describe.
_____
(2) Please complete the following:
a. One of the ways people hurt me is _____
_____
b. I could shock you by_____
_____
c. A mother should _____
_____

d. A father should _____
_____

e. A true friend should _____
_____

(3) Give a brief description of yourself as you would be described by:

a. Your spouse (if married): _____
_____

b. Your best friend: _____
_____

c. Someone who dislikes you: _____
_____

(4) Are you currently troubled by any past rejections or loss of a love relationship? If so, please explain.
_____
_____

10. <u>Biological factors</u>:

Do you have any current concerns about your physical health? Please specify: _____
_____
_____

Please list any medicines you are currently taking, or have taken during the past 6 months (including aspirin, birth control pills, or any medicines that were prescribed or taken over the counter) _____
_____

Do you eat three well-balanced meals each day? If not, please explain: _____
_____
_____

Do you get regular physical exercise? If so, what type and how often? _____
_____

Check any of the following that apply to you:

	NEVER	RARELY	FREQUENTLY	VERY OFTEN
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				
Alcohol				
Coffee				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc.)				
Diarrhea				
Constipation				
Allergies				

Check any of the following that apply to you:

	NEVER	RARELY	FREQUENTLY	VERY OFTEN
High Blood Pressure				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Headaches				
Backache				
Early morning awakening				
Fitful sleep				
Overeating				
Poor appetite				

Underline any of the following that apply to you or members of your family:
thyroid disease, kidney disease, asthma, neurological disease, infectious diseases, diabetes, cancer, gastrointestinal disease, prostate problems, glaucoma, epilepsy, Other: _____

Have you ever had any head injuries or loss of consciousness? Please give details. _____
_____

Please describe any surgery you have had (give dates): _____
_____

Please describe any accidents or injuries you have suffered (give dates): _____
_____

Sequential History:
Please outline your most significant memories and experiences within the following ages:

0-5 _____

6-10 _____

11-15 _____

16-20 _____

21-25 _____

26-30 _____

31-35 _____

36-40 _____

41-45 _____

46-50 _____