

Psychotherapy Checkup

Instructions: To assist me in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

- 1) What is (are) your main reason(s) for this visit?: _____

- 2) How long have you been having the problem(s) (from #1)? _____

- 3) Are you receiving other counseling services at present?: Yes _____ No _____
If Yes, please briefly describe: _____

- 4) Have you received counseling in the past?: Yes _____ No _____
If Yes, please briefly describe: _____

- 5) Have you ever been hospitalized for a mental health condition or an addiction?

- 6) Are you a survivor of emotional, physical, or sexual abuse? (Please circle those which apply.)
- 7) Are you a survivor of other severe trauma? If so, please briefly describe: _____

- 8) Did you grow up in a family where a parent had problems with addictions? __No __ Yes
- 9) List any major illnesses and/or operations you have had: _____

- 10) List any physical concerns you are having at present: (e.g., high blood pressure, headaches, dizziness, etc.): _____

- 11) List any other physical concerns you have experienced in the past: _____

- 12) On average how many hours of sleep do you get daily?: _____
- 13) Do you have trouble falling asleep at night?: __No __ Yes If Yes, describe _____

- 14) Have you gained/lost over ten pounds in the past year?: Yes No, gained lost
 If Yes, was the gain/loss on purpose?: Yes No
- 15) Describe your appetite (during the past week):
 poor appetite average appetite large appetite
- 16) What medications (and dosages) are you taking at present, and for what purpose?:
Medication Purpose

Thoughts and Behaviors

- 17) Please check how often the following thoughts occur to you:
- | | | | | |
|-------------------------------|--------------------------------|---------------------------------|------------------------------------|-------------------------------------|
| a) Life is hopeless. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| b) I am lonely. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| c) No one cares about me. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| d) I am a failure. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| e) Most people don't like me. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| f) I want to die. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| g) I want to hurt someone. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| h) I am so stupid. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| i) I am going crazy. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| j) I can't concentrate. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| k) I am so depressed. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| l) God is disappointed in me. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| m) I can't be forgiven. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| n) Why am I so different? | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| o) I can't do anything right. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| p) People hear my thoughts. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| q) I have no emotions. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| r) Someone is watching me. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| s) I hear voices in my head. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |
| t) I am out of control. | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Frequently |

Please comment about any of the above thoughts you want to clarify.

Symptoms

18) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|--|
| <input type="checkbox"/> aggression | <input type="checkbox"/> fatigue | <input type="checkbox"/> sexual difficulties |
| <input type="checkbox"/> alcohol dependence | <input type="checkbox"/> hallucinations | <input type="checkbox"/> sick often |
| <input type="checkbox"/> anger | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> antisocial behavior | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> hopelessness | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> avoiding people | <input type="checkbox"/> impulsivity | <input type="checkbox"/> thoughts disorganized |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> irritability | <input type="checkbox"/> trembling |
| <input type="checkbox"/> depression | <input type="checkbox"/> judgment errors | <input type="checkbox"/> withdrawing |
| <input type="checkbox"/> disorientation | <input type="checkbox"/> loneliness | <input type="checkbox"/> worrying |
| <input type="checkbox"/> distractibility | <input type="checkbox"/> memory impairment | <input type="checkbox"/> other (specify) |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> mood shifts | _____ |
| <input type="checkbox"/> drug dependence | <input type="checkbox"/> panic attacks | _____ |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> phobias/fears | _____ |
| <input type="checkbox"/> elevated mood | <input type="checkbox"/> recurring thoughts | _____ |

Please comment on any of these symptoms where you would like to clarify or to help me better understand your experience.

Optional Questions

19) List your five greatest strengths:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

20) List your five greatest weaknesses:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

21) List your main social difficulties: _____

22) List your main love and sex difficulties: _____

23) List your main difficulties at school or work: _____

24) List your main difficulties at home: _____

25) List your behaviors that you would like to change: _____

26) Additional information you believe would be helpful: _____

