Today's Date: ______________________________

Your Name: ______________________________

Your Birthdate: ____________________ Age: ______

I am currently: *(Check any that currently apply to you, even if more than one.)*

- □ Dating for ________ months / years
- □ Cohabiting for ________ months / years
- □ Married for ________ months / years
- □ Separated for ________ months / years
- □ Divorced for ________ months / years

Enter the time frame and circle "months" or "years".

Have you been married previously (not counting at present)?
□ Yes □ No If yes, how many times? ______________

Do you have biological children of your own? □ Yes □ No
If yes, how many children do you have? ______________
How many of your bio-children live with you? __________

Do you have step-children? □ Yes □ No
If yes, how many step-children do you have? __________
How many of your step-children live with you? __________

Education: *(highest level)*
□ Some high school □ High school
□ Technical / Trades □ 2-year associate degree
□ Some undergraduate college or university
□ Undergraduate degree □ Some graduate level
□ Graduate degree: ____________________

Income: *(household annual)*
□ $0-30,000 □ $31-60K □ $61-90K
□ $91-120K □$120-150K □ $150K +

Current Occupation: ______________________________
Years at Current Job: ____________ Hrs per week: _______
Do you enjoy your work? □ A lot □ Moderately □ Very little
Career Goals: ______________________________

SYMPTOM CHECKLIST

On a scale of 0-4 (0=none or not applicable, 1=a little, 2=moderate, 3=a lot, 4=extreme) rate how much you have experienced each symptom over **the past two weeks**.

(Circle a number)

Symptom	Rating
1. Feeling sad, down or depressed	0 1 2 3 4
2. Avoiding certain people or places	0 1 2 3 4
3. Loss of interest in activities I normally enjoy	0 1 2 3 4
4. Low energy/feeling tired	0 1 2 3 4
5. Sleep problems (insomnia, not staying asleep, or early waking)	0 1 2 3 4
6. Eating too much or too little	0 1 2 3 4
7. Not able to think clearly	0 1 2 3 4
8. Feeling no pleasure or joy in life	0 1 2 3 4
9. Anxiety attacks	0 1 2 3 4
10. Worrying about things	0 1 2 3 4
11. Angry outbursts	0 1 2 3 4
12. Low self-esteem or low self-confidence	0 1 2 3 4
13. Feeling guilty	0 1 2 3 4
14. Feeling too stressed	0 1 2 3 4
15. Thoughts of suicide	0 1 2 3 4
16. Drinking too much or abusing drugs (i.e. street drugs or prescribed medications)	0 1 2 3 4
17. Acting out other compulsive behaviors (i.e. gambling, sex, porn, shopping, etc.)	0 1 2 3 4
18. Not getting my work done	0 1 2 3 4
19. Feeling unhappy with my workplace	0 1 2 3 4

In regard to your relationship with your spouse or partner, please rate how much you have experienced each of these additional six symptoms in your relationship over **the past two weeks**.

(Circle a number)

Symptom	Rating
20. Not talking to each other	0 1 2 3 4
21. Having bad arguments	0 1 2 3 4
22. Lack of trust between us	0 1 2 3 4
23. Feeling lonely in the relationship	0 1 2 3 4
24. Lack of affection and caring between us	0 1 2 3 4
25. Feeling unhappy about our relationship	0 1 2 3 4
Symptom Total (sum of all 25 symptoms)	**/ 100**

Medical: Do you have any medical problems? □ Yes □ No
If yes, please list them: ______________________________

Do you take any prescription **Medications**? □ Yes □ No
If yes, please list them:

Medication	*Dose*	*Purpose*	*Since*

Do you **Exercise**? □ Yes □ No If yes, what do you do?
____

Do you drink **alcohol**? □ Yes □ No
If yes, estimate how many times you typically drink in a month (i.e. how many drinking occasions): ____________

Estimate how many standard drinks you typically drink per occasion (estimate your range if it varies): ____________

Do you **smoke** tobacco? □ Yes □ No
If yes, please estimate quantity per day: ____________

Do you drink **coffee/ tea?** □ Yes □ No
If yes, please estimate quantity per day: ____________

Do you use any **illicit drugs**? □ Yes □ No
If yes, please specify: ______________________

If you drink alcohol or use illicit drugs, please answer the following questions:

C.	Have you ever thought you should **Cut down** on your drinking/ drug use?	□ Yes □ No
A.	Have people **Annoyed** you by criticizing your drinking/ drug use?	□ Yes □ No
G.	Have you ever felt bad or **Guilty** about your drinking/ drug use?	□ Yes □ No
E	Have you ever had a drink / used drugs in the morning (**Eye opener**) to steady your nerves or to get rid of a hangover?	□ Yes □ No

Are you concerned about the alcohol and/or drug use of anyone close to you? □ Yes □ No If yes, who?
____

In any of your current relationships, have you been:
Physically assaulted (hit, slapped, kicked, pushed, held down)?
□ Yes □ No If Yes, By? ____________________________
The subject of demeaning, degrading comments or put downs?
□ Yes □ No If Yes, By? ____________________________
Sexually abused or coerced into unwanted sexual activity?
□ Yes □ No If Yes, By? ____________________________

In any of your past relationships, have you been:
Physically assaulted (hit, slapped, kicked, pushed, held down)?
□ Yes □ No If Yes, By? ____________________________
The subject of demeaning, degrading comments or put downs?
□ Yes □ No If Yes, By? ____________________________
Sexually abused or coerced into unwanted sexual activity?
□ Yes □ No If Yes, By? ____________________________

STRESSORS IN YOUR LIFE

Check those that apply (*using the left column*). If you check more than one, please select your top three and rank them (*using the right column*) from highest to lowest in terms of the priority you place on resolving them (1=highest priority, 2=second highest, 3=third highest).

(√) (Check all that apply)	Rank
___ Depressed Mood	_______
___ Anxiety	_______
___ Anger Management	_______
___ Self-Esteem or Confidence	_______
___ Social Difficulties	_______
___ Stress Management	_______
___ Substance Abuse (Alcohol/Drugs)	_______
___ Gambling Difficulties	_______
___ Other Addictions (i.e. Porn, Sex, Shopping)	_______
___ Eating Disorder	_______
___ Weight Management / Body Image	_______
___ Spiritual Problems	_______
___ Bereavement/ Loss	_______
___ Work problems	_______
___ Education/ Career Concerns	_______
___ Financial Concerns	_______
___ Legal Concerns	_______
___ Medical Issues	_______
___ Domestic Violence or Abuse (Current)	_______
___ Premarital Counselling	_______
___ Communication Problems/Relationship Conflict	_______
___ Sexual Intimacy Concerns	_______
___ Emotional or Sexual Infidelity/affairs	_______
___ Emotionally disconnected from spouse/partner	_______
___ Other Marital/Relationship Concerns	_______
___ Separation / Divorce / Relationship Break-Up	_______
___ Custody Concerns	_______
___ Parenting	_______
___ Parent-Adult Child Relations	_______
___ Blended Family Issues	_______
___ Family Conflict	_______
___ Child – Behavioral Problems	_______
___ Child – Mood / Anxiety Problems	_______
___ Child – Academic Problems	_______
___ Child – Social/ Relational Problems	_______
___ Other __________________________	_______

PREVIOUS TREATMENT

Have you participated in therapy or counseling in the past?
□ Yes □ No If yes, please specify:

Date	Duration	Therapist / Location	Was it Helpful?

Who do you turn to for social support (e.g. for encouragement, advice, friendship, etc.)?
____
____
____

Are there any organizations or agencies that you are currently receiving assistance or support from? □ Yes □ No If yes, please specify: ______________________________
____
____

EXTENDED FAMILY HISTORY OF PSYCHOSOCIAL / HEALTH DIFFICULTIES

Please check any of the conditions below that are or have been present in your extended family. Please write any additional explanatory comments that may be helpful for your therapist to understand.

	Who? When?
□ Depression	______________________
□ Bipolar Disorder	______________________
□ Schizophrenia	______________________
□ Other psychiatric disorders (i.e. psychosis, hallucinations)	______________________
□ Suicide	______________________
□ Physical / Sexual Abuse	______________________
□ Substance Abuse (Alcohol/Drugs)	______________________
□ Autism/Asperger's Syndrome	______________________
□ Eating Disorder	______________________
□ Chronic Illness (please specify illness)	______________________
□ Accidental or Untimely Death	______________________
□ ADHD or Learning Disorders	______________________
□ Other	______________________

OTHER INFORMATION

Please include here any additional background information you feel would be helpful for your therapist to know:
____
____
____
____
____