

Parental Information

___ Parents legally married

___ Parents have ever been separated

___ Parents ever divorced

Mother remarried: No. of times ___

Father remarried: No. of times ___

Education

Highest degree earned: _____

Major: _____ Minor: _____

Development

Are there special, unusual, or traumatic circumstances that affected your development? ___ Yes ___ No

If YES, please describe: _____

Has there been history of child abuse? ___ Yes ___ No

If YES, which type(s)? ___ Sexual ___ Physical ___ Verbal

Other childhood issues? ___ Neglect ___ Inadequate nutrition ___ Other (please specify) _____

Comments re: childhood development _____

Social Relationships

Check how you generally get along with other people: (check all that apply)

___ Affectionate ___ Aggressive ___ Avoidant ___ Fight/argue often ___ Follower

___ Friendly ___ Leader ___ Outgoing ___ Shy/Withdrawn ___ Submissive

___ Other (please specify) _____

Sexual Orientation _____ Comments: _____

Sexual Dysfunction? ___ Yes ___ No If YES, please describe: _____

Spiritual/Religious

How important to you are spiritual matters? ___ Not ___ Little ___ Moderate ___ Very

Are you affiliated with a spiritual or religious group? ___ Yes ___ No

If YES, describe: _____

How would you describe your spiritual/religious beliefs? _____

Legal

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If YES, please describe and indicate the court or hearing/trial dates and charges: _____

Are you now or have you ever been on probation or parole? ___ Yes ___ No

If YES, please describe: _____

Employment

Currently employed? ___ Yes ___ No Employer _____

Current position _____

Military

Military Experience? ___ Yes ___ No

Combat Experience? ___ Yes ___ No

Branch of Service _____

Duty Station(s) _____

Current Military Status: ___ Active ___ Retired ___ Reserves ___ Nat'l Guard ___ Discharged

If Discharged:

Rank at time of Discharge _____

Type of Discharge _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g. art, books, music, crafts, physical fitness, outdoor activities, church activities, etc.) _____

Medications

Name of Medication	Dosage	Purpose	Prescribing Doctor

Medical/Physical Health

Are you currently experiencing any of the following?

AIDS		Diarrhea		Hepatitis	
Alcoholism		Difficulty breathing		High blood pressure	
Abdominal pain		Difficulty handling money		Kidney problems	
Abortion		Dizziness		Loss of pleasure or enjoyment	
Allergies		Drug abuse		Low energy	
Anemia		Ear infections		Mononucleosis	
Appendicitis		Eating problems		Menstrual pain	
Arthritis		Epilepsy		Neurological disorder	
Asthma		Fainting		Nausea	
Anxiety		Fears		Nightmares	
Bed Wetting		Feeling angry/resentful		Panic	
Cancer		Feel life is not worthwhile		Poor appetite	
Chest pain		Feeling sad or hopeless		Problems with sex	
Chronic pain		Feeling tired or discouraged		Thoughts of suicide	
Cold/cough		Fighting/arguments in your family		Using drug	
Constipation		Forgetting things		Using alcohol	
Dental problems		Having frightening thoughts			
Desire to end your life		Headaches			
Diabetes		Heart racing			

Family Health History

Please describe any mental health issues (if any) experienced by family members or relatives:
