History and Personal Data Questionnaire

Date_____

Name_____ Date of Birth_____ Age___

Main reason for seeking help at this time:

_____
_____
_____
_____

Current Problems or Symptoms

Please read each item below and determine which statement is true for you. Then, place an "X" where it would best indicate how often you feel the statement applies to you *during the past month or since your last visit.*

	DURING THE PAST	**0 (never)**	**5**	**10(always)**
	MONTH OR SINCE			
	LAST VISIT			
1.	Wake up at night in the early morning			
	and unable to return to sleep.			
2.	Very restless sleep.			
3.	Fatigue or loss of energy.			
4.	Decreased sex drive.			
5.	Unable to enjoy life; have lost a			
	zest for life.			
6.	Have withdrawn from others.			
7.	Strong thoughts about suicide.			
8.	Loss of appetite.			
9.	Memory problem, forgetfulness,			
	poor concentration.			
10.	Feel irritable, or easily frustrated.			
11.	Feelings of sadness or hopelessness.			
12.	Sleeping a lot.			
13.	Decreased need for sleep.			
14.	Increased sex drive.			
15.	Increased energy.			
16.	So happy or energetic that people			
	describe me as "manic".			
17.	Can't get to sleep.			

18.	Sudden episodes of nervousness or panic.	**0 (never) 5 10(always)**
19.	Fear of losing self-control.	
20.	Palpitations or rapid heart beat.	
21.	Shortness of breath.	
22.	Feel tense or anxious all day.	
23.	Feel very anxious in social situations.	
24.	Have recurring, troubling thoughts, images or impulses that I can't get out of my mind.	
25.	Repetitive behaviors such as excessive hand-washing, etc.	
26.	Feel very confused about my thoughts.	
27.	Strong or bizarre thoughts.	
28.	Hallucinations, hear voices, or see things that aren't there.	
29.	Very peculiar experiences that others don't understand.	
30.	Feel ready to explode.	
31.	Excessive use of alcohol/drugs.	
32.	Thoughts about harming someone.	
33.	Unusual eating habits.	

34. Weight loss – how much in past month? _____ lbs
Weight gain – how much in past month? _____ lbs
Have you been trying to diet? _____Yes _____No

35. In the past I have tried to cut down on my use of alcohol or drugs. _____Yes _____ No

Previous treatment for Psychological or Emotional Problems

Year	Problem	Therapist/Location	Hospitalization or Medical Treatment