

About You:

Thank you for choosing Turning Point Counseling! To make your time here more productive, please assist the professional staff by completing this questionnaire. The questions are designed to provide information for the purpose of knowing you better. The information that you provide will be held in strict confidence. Naturally, we encourage you to take your time and learn from your responses. Please omit any questions that do not apply to you and *feel free to write in the margins*; you don't need to confine your answers to a box! Thank you for your help. ***Please print.***

Legal Name: _____ Today's Date: _____

Preferred Name: _____ Pronouns: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Other: _____

OK to leave messages? Yes No If **yes**, how may we identify ourselves? ("*Counselor*," by name, or other):

Best days and times to reach you: _____

Age: _____ Date of Birth: _____ Sex Assigned at Birth: Male Female Intersex

Gender Identity: Male Female Transgender Intersex Other: _____

Sexual Orientation: _____

Religion: _____ Spiritual, but not religious

Ethnicity: Black/African-American Caucasian Hispanic Asian Other: _____

Educational/Vocational History:

Highest grade or education degree completed: Less than a high school degree High school GED
 Associate's Degree Bachelor's Degree Master's Degree Professional Degree Doctorate Degree

School(s) Attended: _____ Major/Area of Study: _____

Any problems while you were in school? _____

Occupation: _____ How long have you had your present job? _____

Place of Employment: _____ Part Time or Full time

Annual income: >\$20K \$21- \$35K \$36- \$50K \$51- \$65K \$66-\$80K \$81-\$100K \$100K+

Any problems at work? _____

Military/Veteran Status: Yes No Branch _____ Dates of service: _____

Rank/Position in service: _____

Stationed: _____ Did you serve in combat? Yes No

Relationship History:

Current Relationship Status (check all that apply):

- Single Married Civil Union Divorced Separated Widowed
- Committed Engaged Co-habiting Same sex relationship

Date of current marriage/civil union: ____/____/____

If you are in a relationship do your family/friends accept your partner? Yes No

Date(s) of previous marriage/union(s):

From: ____/____/____ To: ____/____/____ How did marriage/union end?: _____

From: ____/____/____ To: ____/____/____ How did marriage/union end?: _____

About Your Partner:

In two or three words, describe your partner: _____

Name of partner: _____ Sex: Male Female Transgender Intersex

Is your partner living in the home? Yes No Do your partner’s family/friends accept you? Yes No

Ethnicity: Black/African American Caucasian Hispanic Asian Other: _____

Religion: _____ Spiritual, but not religious

Age ____ Is your partner employed? Yes No If yes, where: _____

Partner’s income: >\$20K \$21- \$35K \$36- \$50K \$51- \$65K \$66-\$80K \$81-\$100K \$100K+

Highest grade or education degree completed: Less than a high school degree High school GED

Associate’s Degree Bachelor’s Degree Master’s Degree Professional Degree Doctorate Degree

Do you have any concerns or questions about your partner or marital status that we should be aware of, or that you would like to discuss? _____

Family Background:

In two or three words, describe your family of origin: _____

Are your parents married? _____

Is your Father living? Yes No Date and Cause of Death: _____

Is your Mother living? Yes No Date and Cause of Death: _____

Mother’s occupation: _____ Father’s occupation: _____

Briefly describe the quality or nature or your relationship with your parents and note any questions or concerns you might wish to raise regarding that relationship: _____

Siblings: Please list your brothers and sisters and their ages:

<u>Name</u>	<u>Gender</u>	<u>Age</u>	<u>Name</u>	<u>Gender</u>	<u>Age</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Briefly describe the quality or nature of your relationship with your siblings and note any questions or concerns you might wish to raise regarding any relationship: _____

Children: Please list your children and stepchildren

<u>Name</u>	<u>Gender</u>	<u>Date of Birth</u>	<u>Age</u>	<u>Living with you? Yes or No</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Child Concerns: Identify by writing the name(s) of the child (children) in the space next to the concern you or your partner have: If you do not have children, please skip and go to the next section.

- | | | |
|------------------------------------|-------------------------------------|------------------------|
| Bad dreams: _____ | Moods: _____ | Health problems: _____ |
| Hyperactivity: _____ | Worry: _____ | Fighting: _____ |
| Fears: _____ | Arguing: _____ | Jealousy: _____ |
| Complaining: _____ | Sleep: _____ | Depression: _____ |
| Unhappiness: _____ | Stealing: _____ | Immaturity: _____ |
| Friendships: _____ | Shyness: _____ | Sexual Abuse: _____ |
| Physical Abuse: _____ | Anger: _____ | Bed Wetting: _____ |
| Disobedience: _____ | Lying: _____ | Attentiveness: _____ |
| Sexual Concerns: _____ | Allergies: _____ | Running away: _____ |
| Drug/Alcohol Use: _____ | Impulsiveness: _____ | School Work: _____ |
| Relations with stepchildren: _____ | School Performance: _____ | |
| Visitation arrangements: _____ | Interference with ex-partner: _____ | |

Please state briefly any special concerns or questions about your children that you think we should discuss:

Names and Relationships of people who currently live with you:

Name Gender Age Relationship How long have they lived with you?

Do you or anyone in your family have:

Any history of domestic violence/intimate partner violence? No Yes If yes, please explain...

self: _____ others: _____

Any history of alcohol abuse or dependence? No Yes If yes, please explain...

self: _____ others: _____

Any history of drug abuse or dependence? No Yes If yes, please explain...

self: _____ others: _____

Any history of sexual abuse, sexual assault, rape, or molestation? No Yes If yes, please explain...

self: _____ others: _____

Any history of mental illness? No Yes If yes, please explain...

self: _____ others: _____

Health Concerns:

Do you have any allergies? _____

List any illnesses, medical problems, surgeries, or disabilities that have affected you: _____

List all current medications:

List all previous mental health help you have received for personal, marital, or family concerns:

Kind of Treatment Date Name of Provider Reason

List previous diagnoses if known:

Have you ever had thoughts about suicide? No Yes If so, do you currently have them? No Yes

If yes, please describe: _____

Have you ever attempted suicide? No Yes If so, when? _____

Have you ever been hospitalized for suicidal thoughts/actions? No Yes

If yes, when and where? _____

Problems/Personal Concerns Checklist: Please check (✓) any of the following that may apply

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> anxiety or nervousness | <input type="checkbox"/> panic attacks | <input type="checkbox"/> excessive caffeine use | |
| <input type="checkbox"/> fears and worries | <input type="checkbox"/> obsessive thoughts | <input type="checkbox"/> excessive alcohol use | |
| <input type="checkbox"/> heart palpitations or pounding | <input type="checkbox"/> compulsive behaviors | <input type="checkbox"/> excessive medication use | |
| <input type="checkbox"/> shortness of breath/rapid breathing | <input type="checkbox"/> troublesome dreams | <input type="checkbox"/> illicit drug use | |
| <input type="checkbox"/> high blood pressure (hypertension) | <input type="checkbox"/> self-harm | <input type="checkbox"/> sexual concerns/functioning problem | |
| <input type="checkbox"/> frequent upset stomach/nausea | <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> pregnancy | <input type="checkbox"/> parenting |
| <input type="checkbox"/> diarrhea/constipation | <input type="checkbox"/> mania | <input type="checkbox"/> infertility | <input type="checkbox"/> separation |
| <input type="checkbox"/> muscle tension/spasticity/cramps | <input type="checkbox"/> problems with temper | <input type="checkbox"/> adoption | <input type="checkbox"/> divorce |
| <input type="checkbox"/> coldness or numbness in fingers | <input type="checkbox"/> self-control | <input type="checkbox"/> dating concerns | <input type="checkbox"/> couple problems |
| <input type="checkbox"/> dizziness or fainting spells | <input type="checkbox"/> mood swings | <input type="checkbox"/> premarital concerns | <input type="checkbox"/> assertiveness |
| <input type="checkbox"/> frequent or severe headaches | <input type="checkbox"/> illegal behavior | <input type="checkbox"/> infidelity by partner | <input type="checkbox"/> infidelity (self) |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> gambling | <input type="checkbox"/> chronic illness | <input type="checkbox"/> chronic pain |
| <input type="checkbox"/> inability to concentrate | <input type="checkbox"/> discrimination | <input type="checkbox"/> physical abuse | <input type="checkbox"/> emotional abuse |
| <input type="checkbox"/> crying spells | <input type="checkbox"/> education issues | <input type="checkbox"/> sexual abuse/assault | <input type="checkbox"/> trauma |
| <input type="checkbox"/> frequent or early wakening | <input type="checkbox"/> legal problems | <input type="checkbox"/> fear of abandonment | <input type="checkbox"/> flashbacks |
| <input type="checkbox"/> problems falling asleep | <input type="checkbox"/> risky behavior | <input type="checkbox"/> loss of faith in others | <input type="checkbox"/> despair |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> intrusive thoughts | <input type="checkbox"/> feelings of emptiness | <input type="checkbox"/> helplessness |
| <input type="checkbox"/> depression | <input type="checkbox"/> bizarre thoughts | <input type="checkbox"/> self-doubt/insecurity | <input type="checkbox"/> hopelessness |
| <input type="checkbox"/> unhappiness | <input type="checkbox"/> financial concerns | <input type="checkbox"/> anger with God | <input type="checkbox"/> confusion |
| <input type="checkbox"/> loss of interest | <input type="checkbox"/> employment issues | <input type="checkbox"/> loss of faith in God | <input type="checkbox"/> loss of meaning |
| <input type="checkbox"/> loneliness | <input type="checkbox"/> issues with friends | <input type="checkbox"/> body image issues | <input type="checkbox"/> sexuality issues |
| <input type="checkbox"/> loss of pleasure | <input type="checkbox"/> pornography/cybersex | <input type="checkbox"/> gender issues | <input type="checkbox"/> gender dysphoria |
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> communicating | <input type="checkbox"/> other: | |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> loss of love | | |
| <input type="checkbox"/> eating disorder | <input type="checkbox"/> grief/bereavement | | |
| <input type="checkbox"/> sadness | <input type="checkbox"/> guilt or shame | | |
| <input type="checkbox"/> no motivation | <input type="checkbox"/> inferiority | | |
| <input type="checkbox"/> decline in ADLs | <input type="checkbox"/> problems with decision making | | |

Past Coping Strategies:

Interests and Hobbies:

Presenting Problem(s): (state in your own words the reasons for which you are requesting help) Please give a brief history of the problem(s)

What are your goals or what do you hope to accomplish in counseling?

Are there any other pertinent issues that have not been covered in this questionnaire?

Comments, questions, or concerns about Counseling: _____

*Please rate your feelings regarding how hopeful you are that counseling will help:
(please mark your response)*

