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/Affectional 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-habitating ☐ 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)/significant relationships:

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: _____

_____

Describe any pertinent Family-of-Choice relationships: _____

_____

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

Name	**Gender**	**Age**	**Name**	**Gender**	**Age**

Briefly describe the quality or nature or 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*

Name	**Gender**	**Date of Birth**	**Age**	**Living with you? Yes or No**

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? And by what means? _____

_____

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*

___ anxiety or nervousness
___ fears and worries
___ heart palpitations or pounding
___ shortness of breath/rapid breathing
___ high blood pressure (hypertension)
___ frequent upset stomach/nausea
___ diarrhea/constipation
___ muscle tension/spasticity/cramps
___ coldness or numbness in fingers
___ dizziness or fainting spells
___ frequent or severe headaches
___ memory problems
___ inability to concentrate
___ crying spells
___ frequent or early wakening
___ problems falling asleep
___ nightmares
___ depression
___ unhappiness
___ loss of interest
___ loneliness
___ loss of pleasure
___ lack of appetite
___ excessive appetite
___ eating disorder
___ sadness
___ no motivation
___ decline in ADLs

___ panic attacks
___ obsessive thoughts
___ compulsive behaviors
___ troublesome dreams
___ self-harm
___ suicidal thoughts
___ mania
___ problems with temper
___ self-control
___ mood swings
___ illegal behavior
___ gambling
___ discrimination
___ education issues
___ legal problems
___ risky behavior
___ intrusive thoughts
___ bizarre thoughts
___ financial concerns
___ employment issues
___ issues with friends
___ pornography/cybersex
___ communicating
___ loss of love
___ grief/bereavement
___ guilt or shame
___ inferiority
___ problems with decision making

___ excessive caffeine use
___ excessive alcohol use
___ excessive medication use
___ illicit drug use
___ sexual concerns/functioning problem
___ pregnancy
___ infertility
___ adoption
___ dating concerns
___ premarital concerns
___ infidelity by partner
___ chronic illness
___ physical abuse
___ sexual abuse/assault
___ fear of abandonment
___ loss of faith in others
___ feelings of emptiness
___ self-doubt/insecurity
___ anger with God
___ loss of faith in God
___ body image issues
___ gender issues
___ other:

___ parenting
___ separation
___ divorce
___ couple problems
___ assertiveness
___ infidelity (self)
___ chronic pain
___ emotional abuse
___ trauma
___ flashbacks
___ despair
___ helplessness
___ hopelessness
___ confusion
___ loss of meaning
___ sexuality issues
___ gender dysphoria

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?

_____

_____

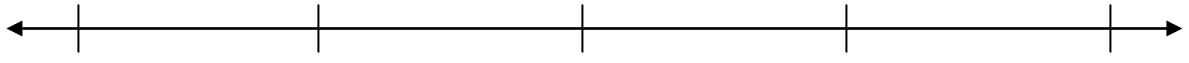
_____

Comments, questions, or concerns about Counseling: _____

_____

Please rate your feelings regarding how hopeful you are that counseling will help:

(please mark your response)



Hopeless | Somewhat Hopeless | Unsure | Somewhat Hopeful | Very Hopeful