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 specific 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:

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):

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

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

Do you or anyone in your family have:

Any history of domestic violence? ☐ No ☐ Yes If **yes**, please explain

self:_____ others: _____

Any history of alcohol abuse? ☐ No ☐ Yes If **yes**, please explain

self:_____ others: _____

Any history of drug abuse? ☐ No ☐ Yes If **yes**, please explain

self:_____ others: _____

Any history of sexual abuse? ☐ No ☐ Yes If **yes**, please explain

self:_____ others: _____

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

self:_____ others: _____

About Your Partner: ***If your partner/spouse is also filling out an "About You" please skip and go to "Feelings About Your Partner" section.***

Name of partner:_____ Sex: ☐ Male ☐ Female ☐ Transgendered ☐ 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

Feelings About Your Partner:

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? _____

_____

_____

In two or three words, describe your partner: _____

Family Background:

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

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: _____

_____

_____

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**

Names and Relationships of other people who currently live with you:

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

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 "Health Concerns" section below.***

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:

_____

Health Concerns:

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

_____

_____

_____

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? _____

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

Kind of Treatment	**Date**	**Name of Provider**	**Reason**

List all current medications:

_____

_____

_____

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

___ anxiety, tension, nervousness
___ fears and worries
___ heart palpitations or pounding
___ shortness of breath/ rapid breathing
___ high blood pressure/hypertension
___ frequent upset stomach/indigestion/nausea
___ muscle tension/spasticity/cramps
___ coldness or numbness in fingers
___ stiffness/aching/burning sensation in joints
___ dizziness or fainting spells
___ frequent or severe headaches
___ memory problems
___ inability to concentrate
___ crying spells
___ frequent or early wakening
___ problems falling asleep
___ depression
___ despair
___ unhappiness
___ loneliness
___ grief/bereavement
___ lack of appetite
___ excessive appetite
___ eating disorder
___ guilt or shame
___ decision making
___ sadness
___ other:

___ panic attacks
___ suicidal thoughts
___ self-harm
___ loss of pleasure
___ loss of interest
___ troublesome dreams
___ bizarre thoughts
___ temper
___ self-control
___ gambling
___ mood swings
___ risky behavior
___ divorce
___ separation
___ dating
___ friends
___ ambition
___ obsessive thoughts

___ excessive caffeine use
___ excessive alcohol use
___ excessive medication use
___ drug use
___ sexual concerns
___ sexual functioning problem
___ infertility
___ hormonal imbalances (eg. Menopause, PMS)
___ pregnancy
___ diarrhea/constipation
___ chronic pain
___ chronic illness
___ discrimination
___ education
___ legal matters
___ finances
___ physical abuse
___ criminal behavior
___ pornography/cybersex
___ infidelity of self
___ infidelity of partner
___ internet relationships
___ loss of faith in others
___ loss of love
___ assertiveness
___ shyness
___ compulsive behaviors

___ mania
___ self-concept
___ sexuality
___ gender issues
___ confusion
___ adoption
___ parenting
___ sexual abuse
___ sexual response
___ couple problems
___ premarital concerns
___ communicating
___ loss of meaning
___ loss of faith in God
___ anger with God
___ self-doubt/insecurity
___ inferiority
___ decline in ADLs

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)***

_____

_____

_____

_____

_____

_____

_____

If you are experiencing problems in your relationships with others please indicate by checking all that apply:

☐ Partner ☐ Child/Children ☐ Parent(s) ☐ Sibling(s) ☐ Extended Family ☐ In-Laws ☐ Friends

☐ Co-workers ☐ Other: _____

Comments:_____

_____

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 circle your response)