Transformed Lives Inc. - Psychosocial Questionnaire

Client Name:_____
Last First MI (preferred name)

Counselor Name:_____ Date of First Appointment:_____
DOB _____ What church do you attend?_____

In a few words, please explain why you have come to Transformed Lives Inc
_____
_____
_____

How long has this been a problem for you? _____

How have you tried to solve this problem? _____
_____
_____

In a few words, please describe your talents, abilities and interests.
_____
_____
_____

Areas of Personal Concern

Please Rate Only the Items You Are Currently Concerned About by Placing a Number in the Box Beside the Concern
1= Mildly Upsetting 2= Moderately Severe 3=Very Severe 4= Extremely Severe 5= Totally Incapacitating

	Stress		Hopelessness		Physical Abuse (Past or Present)
	Anxiety		Suicidal Thoughts		Sexual Abuse (Past or Present)
	Mood Swings		Desire to Hurt Others		Emotional Abuse (Past or Present)
	Guilt		Marital Problems		Alcohol Use
	Fearfulness		Family Problems		Drug Use
	Forgetfulness		Financial Problems		Eating Disorders
	Grief		Work Problems		Self-Image/Acceptance
	Anger/Temper		Legal Problems		School Problems

Medical or Physical Concerns

Please Rate Only the Items You Are Currently Concerned About by Placing a Number in the Box Beside the Concern
1= Mildly Upsetting 2= Moderately Severe 3=Very Severe 4= Extremely Severe 5= Totally Incapacitating

	Headaches		Muscle Tension		Mental Illness
	Sleeplessness		Nausea		Gynecological Problems
	Too Much Sleep		Constipation		Recent Weight Gain
	Breathing Difficulty		Diarrhea		Recent Weight Loss
	Chest Pain		Vomiting		ADHD
	Blurred Vision		Chronic Pain		Nightmares/sleepwalking
	Fatigue		Dizziness		Chronic illness

	Unable to Relax		Feeling Panicky		Difficulty Concentrating

Allergies (Specify) _____

_____

How would you describe your eating habits? _____

_____

How would you describe your exercising habits? _____

_____

Hospitalizations

Year	Hospital	Diagnosis

Name of primary care physician: _____

Date of your last physical examination: _____

Name of past or present psychiatrists or therapists: _____

_____

Are you currently being treated for any physical or mental illness? Explain: _____

_____

_____

Describe any previous experiences with counseling: _____

_____

_____

_____

_____

Substance Use History

Drug	When used (P for present)	How much & often?
Caffeine		
Tobacco		
Alcohol		
Marijuana		
Pain killers		
Inhalants		
Cocaine		
Heroine		
Ecstasy		

Ice/Crystal Meth		
Other:		

Please list all medications/herbs/vitamins you are currently taking: _____

_____

Do you regularly use laxatives or diuretics? Explain: _____

_____

Personal and Family History

Please Mark All That Apply to You or a Member of Your Family Please Indicate Personal and/or which Family Member			
	Hyper/Hypo Thyroid		Anxiety Disorder
	Alcoholism		Depression
	Heart Disease		Manic Depression
	Arthritis		Schizophrenia
	Asthma		Hyperactivity
	Diabetes		Chemical Addiction
	Cancer		Gambling Addiction
	Seizures		Sexual Dysfunction
	High Blood Pressure		Sexual Addiction

Current Family

Children (If a step-child, note with an *)

Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____ Sex: _____

Name: _____ Age: _____ Sex: _____

Marital Status

_____Single (never married) _____Married _____Widowed _____Separated _____Divorced

Name of Spouse: _____

Date of Marriage: _____ Your Age: _____ (at Time of Marriage) Spouse Age: _____ (at Time of Marriage)

Describe your relationship: _____

_____

_____

Previous Marriages/Significant Relationships:

Ever been married before? _____

Family of Origin

Father's Name: _____ DOB/Age: _____ / _____
Living: ____Yes ____ No
Education: _____ Occupation: _____
Describe his personality: _____
How did he show love? _____
Describe your relationship: _____
_____

Mother's Name: _____DOB/Age: _____ / _____
Living?: ____Yes ____ No
Education: _____ Occupation: _____
Describe her personality: _____
How did she show love? _____
Describe your relationship: _____
_____

Describe your parents' relationship: _____
_____
_____

Are they divorced? ____ No ____Yes (Date: _____)
(If yes answer the following if applicable):

Step-father's Name: _____ DOB/Age: _____ / _____
Living?: ____Yes ____No
Education: _____ Occupation: _____
Describe his personality: _____
How did he show love? _____
Describe your relationship: _____
_____
Describe their marriage: _____
_____

Step-mother's Name: _____DOB/Age: _____ /_____
Living?: ____Yes ____ No
Education: _____ Occupation: _____
Describe her personality: _____
How did she show love? _____
Describe your relationship: _____

Describe their marriage: _____

_____

_____

Brothers and Sisters

Name	Living?	Age

(List others on the back of this sheet.)

Was favoritism shown to you or specific siblings? Explain. _____

_____

_____

How was discipline handled? _____

_____

_____

Support System

What are the significant relationships in your life? Who do you look to for support?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Professional History

Level of education completed:_____

List any degrees or certifications: _____

Occupation:_____

Do you have any future career ambitions? _____

_____