

Cognitive Behavioral Therapy Services, Inc.

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Please provide the following information to help us in planning services for you. All information is kept confidential and will not be released without your prior consent.

Patient Name:	Home Tel: () -	Cell/Work: () -
Date of Birth:	Marital Status:	Remarried? Yes #___ / No
Social Security # - -	Education (Yrs.):	Highest Degree:
Home Address:	City:	State: Zip:
Names of Parents/Guardians (<i>if minor</i>):		
Social Security # - -	Name:	
Home Tel: () -	Cell/Work: () -	
Patient's Occupation:	Position:	How long?
Employer:		
Work Address:	City:	State: Zip:
Name of Primary Physician:		
Physician's Address :	City:	State: Zip:
Physician's Tel: () -	Fax: () -	
Are you currently seeing a Psychiatrist?		
Psychiatrist 's Address :	City:	State: Zip:
Tel: () -	Fax: () -	

Please list any people currently living in your home:

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

Person to notify in case of an emergency (required information):

Name:	Relationship:		
Address:	City:	State:	Zip:
Home Tel:	Cell/work:		

Please complete this section if you believe insurance may cover all or a portion of your visits:

Insurance Co:	Name of policy holder:
Group#:	Policy#:

I _____ hereby authorize Cognitive Behavioral Therapy Services to release any information to the above named insurance company which might be needed to process this claim. This information may include the diagnosis, dates of service and any other needed information to assist in the processing your claim. Your information may also be shared with Theramanager to aid in your billing and your insurance claims.

Signature

Date:

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I. Current Problems

What are the chief problems that caused you to seek treatment at this time: _____

Circle a number indicating the severity of your problems **described above:** (circle number)

None	Slight	Mild	Moderate	Very	Extreme	Totally Incapacitating
0	1	2	3	4	5	6

Have you been experiencing any these problems listed? If yes, please indicate how long you have had the symptom. Example: Nervousness (3 weeks)

Nervousness ()	Depression ()	Fears ()	Mood Changes ()
Shyness ()	Sexual Problems ()	Suicidal Thoughts ()	Family Conflict ()
Divorce ()	Boredom ()	Finances ()	Racing Thoughts ()
Drug Use ()	Alcohol Use()	Friends ()	Confusion()
Anger ()	Self-control()	Unhappiness ()	Attention()
Sleep ()	Stress()	Work ()	Organization ()
Relaxation()	Headaches()	Dating ()	Social Anxiety ()
Legal Matters ()	Chronic Pain()	Decision Making ()	Thinking Problems ()
Loneliness ()	Self-esteem()	Concentration ()	Obsessions ()
Education ()	Career Choices ()	Performance Anxiety ()	Compulsiveness()
Health Problems()	Nightmares ()	Marital/ Relationship ()	Family Conflict ()
Parenting ()	Eating Disorder ()	Irritability ()	Weight loss ()

Circle a number indicating the severity of your problems **described above:** (circle number)

None	Slight	Mild	Moderate	Very	Extreme	Totally Incapacitating
0	1	2	3	4	5	6

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When did your problems begin? _____

What was going on in your life at that time? _____

What seems to worsen your problems? _____

What seems to help your problems? _____

Please briefly describe what you do on a typical weekday, starting with the time you wake up in the morning, and ending with the time you go to sleep at night. _____

Did this pattern change when your present difficulties begin? Yes _____ No _____

If yes, in what way? _____

Please briefly describe what you do on your weekends or days off. _____

Did this pattern change when your present difficulties begin? Yes _____ No _____

If yes, in what way? _____

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II. Current Social Life

Describe how you are getting along with people other than your family or those with whom you live (e.g., friends, acquaintances, neighbors, co-workers), and how people generally seem to feel about you. If you are having any problems relating to people, please describe those problems.

Have your relationships changed as a result of your current difficulties? Yes ____ No ____ If yes, briefly explain the ways in which they have changed. _____

How difficult is it for you to **make** friends these days?(circle number)

<u>Very Difficult</u>		<u>Somewhat Difficult</u>		<u>About Average</u>		<u>Somewhat Easy</u>		<u>Very Easy</u>	
1	2	3	4	5	6	7	8	9	10

How difficult is it for you to **keep** friends these days?(circle number)

<u>Very Difficult</u>		<u>Somewhat Difficult</u>		<u>About Average</u>		<u>Somewhat Easy</u>		<u>Very Easy</u>	
1	2	3	4	5	6	7	8	9	10

About how many close friends do you have (people you can confide in)? _____

How often do you talk to them? _____

How often do you see them? _____

Rate the degree to which you generally feel relaxed and comfortable in social situations (circle a number)

<u>Very Tense & Uncomfortable</u>		<u>Somewhat Tense & Uncomfortable</u>		<u>Neutral</u>		<u>Somewhat Relaxed & Comfortable</u>		<u>Very Relaxed & Comfortable</u>	
1	2	3	4	5	6	7	8	9	10

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III. Current Work Life

Briefly describe your attitude and behavior at work or school. Describe any problems you are having carrying out your responsibilities or dealing with problems.

Did your attitude or behavior change when your present difficulties began? Yes ___ No ___ If yes, in what way? _____

What do you like about your current line of work? _____

IV. Intimate Relationships

How comfortable are you with the idea of being trusting, open, and close (vulnerable) in a love relationship. (circle a number)

Very Tense & uncomfortable with closeness; very self-Protective	Somewhat Tense & uncomfortable with self-protective	Neutral; Fairly self-protective but willing to be vulnerable at Times	Moderately Relaxed & with closeness; Pretty willing to be vulnerable	Extremely comfortable with closeness very willing to to be vulnerable					
1	2	3	4	5	6	7	8	9	10

IF NOT MARRIED OR COHABITATING: Are you currently dating any one? Yes ___ No ___ If yes,

Are you experiencing significant difficulties in this/these dating relationship(s)? Yes ___ No ___

If yes, please describe. _____

If you are not currently dating anyone, how satisfied are you with this situation (circle a number).

Completely Dissatisfied	Mostly Dissatisfied	Somewhat Dissatisfied	Neutral	Evenly Mixed Feelings	Somewhat Satisfied	Completely Satisfied			
1	2	3	4	5	6	7	8	9	10

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V. Children and Family Relationships

List below each child with whom you have a parental relationship whether as a biological parent, step-parent, or other relationship.

Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		
Name:	Age:	Relationship:
Custody/Living arrangement:		

Do any of your children present special problems to you or your spouse/partner? Yes _____ No _____ if yes, please describe. _____

How would you describe your present relationship with your family of origin? _____

Indicate which, if any of these relationships is currently a significant source of support or distress for you. If a relationship is problematic, describe briefly what the problem(s) seems to be. _____

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VI. Medical History

When was the last time you had a physical examination/check-up? _____

Have you been treated by a physician or hospitalized in the last year? Yes____ No____

If yes, please specify: _____

Have there been any changes in your general health in the past year? Yes____ No____

If yes, please specify: _____

Are you taking any non-psychiatric medication or over-the-counter drugs at the present time? Yes____ No____ If yes, please list:

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Name of Provider</u>
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1.

2.

3.

4.

Have been ever told you have a thyroid problem? Yes____ No____

Have been ever told you have diabetes? Yes____ No____

Do you get short of breath on mild exertion or when you lie down? Yes____ No____

Have you ever had or have a history of: (check all that apply)

Stroke____ Anemia____ Rheumatic Fever____ Asthma____ High/Low Blood Pressure____

Heart Murmur____ Tuberculosis____ Heart Surgery____ Angina____ Ulcers____ Heart Attack____

Are you pregnant or think you may be pregnant? Yes____ No____ N/A____

Have you ever had seizures, convulsions, or epilepsy? Yes____ No____

Do you have a prosthetic heart valve? Yes____ No____

Do you have any other medical condition? Yes____ No____

If yes, specify _____

Do you have any medication or food allergies? Yes____ No____

If yes, specify _____

Have you ever had a major illness or injury? Yes____ No____ If yes, specify _____

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VII. Psychiatric History

Instructions: You will find below a list of questions regarding your psychiatric history. Your answers are important for your evaluation and potential treatment. Also please feel free to discuss any of these questions or your responses with your therapist or staff member. Please fill in choices completely and do not leave any questions blank.

Have you ever seen or heard anything odd or unusual that no one else could see or hear? Yes__ No__?

If you answered yes, answer the following:

a) Were/are these unwanted and/or come on without warning? Yes__ No__

b) Are these experiences upsetting and get in the way of your life? Yes__ No__

Briefly describe: _____

Have you ever been hospitalized for an emotional or psychiatric reason? Yes__No__

If yes, how many times have you been hospitalized? ____

<u>Dates</u>	<u>Name of Hospital</u>	<u>Reason for Hospitalization</u>	<u>Was it helpful?</u>
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1.

2.

3.

Have you received psychiatric or psychological treatment before? Yes__ No__

<u>Dates</u>	<u>Name of Professional</u>	<u>Reason for Treatment</u>	<u>Was it helpful?</u>
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1.

2.

3.

4.

Are you taking any medication for psychiatric reasons? Yes__ No__

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Date Started</u>	<u>Name of Provider</u>
-------------------	-------------------------	---------------------	-------------------------

1.

2.

3.

4.

Previously prescribed medication:

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Date Started</u>	<u>Date Stopped</u>	<u>Name of Provider</u>
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1.

2.

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Psychiatric History cont'd:

Additional previously prescribed medication:

Medication Dosage/Frequency Date Started Date Stopped Name of Provider

3.

4.

Have you ever made a suicide attempt? Yes ___ No ___ If yes, how many times ___ ___

Approximate Date Exactly, what did you do to hurt yourself? Were you hospitalized

1.

2.

3.

Did you ever experience physical abuse as a child? Yes ___ No ___

Did you ever experience physical abuse as an adult? Yes ___ No ___

Did you ever experience sexual abuse as a child? Yes ___ No ___

Did you ever experience rape including date or marital? Yes ___ No ___

Did you ever experience emotional or verbal abuse as a child? Yes ___ No ___

Did you ever experience emotional or verbal abuse as an adult? Yes ___ No ___

Have you ever been in trouble with the law? Yes ___ No ___

Has anyone in your family ever received psychiatric treatment? Yes ___ No ___

Does anyone in your family have a history of mental illness, alcohol, or drug abuse? Yes ___ No ___

If yes, Family Member List specific Psychiatric, drug or alcohol problem

1.

2.

3.

4.

5.

6.

Has anyone in your family ever made a suicide attempt? Yes ___ No ___ If yes, who? _____

Has anyone in your family died from suicide? Yes ___ No ___ If yes, who? _____

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VIII. Alcohol & Drug Use History

When did you last drink alcohol? _____

How much did you drink? _____

How many days per week do you drink? _____ What is the most drinks in one sitting? _____

What is the average amount of drinks you have had during one sitting? _____

Has alcohol ever caused a problem for you? Yes ___ No ___

Has anyone ever told you that alcohol has caused a problem for you or complained about your drinking? Yes ___ No ___

Has your use of alcohol ever caused a relationship problem with anyone? Yes ___ No ___

Has your use of alcohol ever caused any problems at work or performing other responsibilities? Yes ___ No ___

Has your use of alcohol ever caused any legal problems such as being arrested or DUI? Yes ___ No ___

Have you ever gotten "hooked" on a prescribed medication or taken a lot more of it than you were prescribed?

Yes ___ No ___ If yes, please list those medications: _____

Have you ever been hospitalized because of a drug or alcohol problem? Yes ___ No ___ If yes, when and where were you hospitalized? _____

Have you ever been to a detoxification program? Yes ___ No ___ If yes, when and where did you receive such treatment? _____

Have you ever been to a drug or alcohol rehabilitation program? Yes ___ No ___ If yes, when and where did you receive such treatment? _____

Have you ever attended a 12 step meeting such as AA, NA, Al-Anon, Al-Ateen, ACOA? Yes ___ No ___

Have you ever used any street drugs such as Cocaine, Marijuana, Speed (Crystal Meth), LSD, Ecstasy

Other? Yes ___ No ___ If yes, specify _____

Has anyone ever told you that drugs has caused a problem for you or complained about your drug use? Yes ___ No ___

Has your use of drugs ever caused a relationship problem with anyone? Yes ___ No ___

Has your use of drugs ever caused any problems at work or performing other responsibilities? Yes ___ No ___

Have drugs ever caused any physical problems such as headaches, shakiness, stomach aches, seizures, liver damage? Yes ___ No ___

What is the longest period you have been drug free? _____

When was the last time you used any drugs? _____

Has your use of drugs ever caused any psychological problems such as feeling depressed? Yes ___ No ___

Has your use of drugs ever caused any legal problems such as being arrested or DUI? Yes ___ No ___

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IX. Life History

Family of Origin:

Father's name: _____ **Age:** _____

Occupation: _____ **Health:** _____

If deceased, give age at time of death; _____ How old were you? _____

Cause of death: _____

Mother's name: _____ **Age:** _____

Occupation: _____ **Health:** _____

If deceased, give age at time of death; _____ How old were you? _____

Cause of death: _____

Siblings: *Ages of sisters:* _____ *Ages of brothers:* _____

Where do you fit in birth order? _____ Any significant details about your siblings: _____

Disruptions in childhood upbringing:

Did you experience any significant moves as a child? Yes ___ No ___ If yes, how old were you _____

Did you have any significant emotional or behavioral difficulties associated with the move(s)?

Yes ___ No ___ If yes, describe your difficulties: _____

Were you ever separated from one or both your parents for a period of time during your childhood?

Yes ___ No ___ If yes, how old were you? _____

Did you have any significant emotional or behavioral difficulties associated with the move(s)?

Yes ___ No ___ If yes, what were the difficulties and what were the circumstances and reasons for separation? _____

If you were not raised by your parents, who raised you and between what years? _____

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Life History cont'd

How would you characterize your father (or father substitute) when you were a child? _____

What was his attitude toward you as a child? _____

How much were you able to confide in your father as a child? _____

How did your father discipline you when you misbehaved? _____

How would you characterize your mother(or mother substitute) when you were a child? _____

What was her attitude toward you as a child? _____

How much were you able to confide in your mother as a child? _____

How did your mother discipline you when you misbehaved? _____

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Life History cont'd

How did you parents get along? _____

How the children get along? _____

What were some of the important spoken and unspoken rules? _____

How openly were affection and anger expressed? _____

How were problems handled? _____

What was your parents' attitude about sex? How much was sex discussed in the home? _____

Was religion an important part of your upbringing? Yes ___ No ___ If yes, in what ways: _____

How involved were your parents in the social interests of the children? How comfortable did you feel having your friends over the house? _____

If you have a stepparent, how old were you when your parent remarried: _____

If different from above what was your relationship like with him/her: _____

Did you have any particular fears as a child? Yes ___ No ___ If yes, what were they: _____

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IX. School/Occupational/Relationship History:

How did you feel about school as you grew up?

Elementary:

Jr. High/High School:

College/Graduate:

How were your grades on average?

Elementary:

Jr. High:

High School:

College:

Growing up, were you ever in trouble with the police or school authorities? Yes ___ No ___ If yes, how old were you at the time: _____ Describe the specific incidents: _____

Did you graduate from:

High School? Yes ___ No ___ Year _____

A Vocational Training Program? Yes ___ No ___ Year _____

College? Yes ___ No ___ Year _____

Graduate/Professional School? Yes ___ No ___ Year _____

Did you take any time off from school during your education? Yes ___ No ___ If yes why, _____

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School/Occupational/Relationship History cont'd:

Describe the types of jobs you've held and for reasons for leaving past jobs.

<u>Dates</u>	<u>Job Description</u>	<u>Employer</u>	<u>Reason for Leaving</u>
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Have you ever made a career change ?Yes ____ No ____ If yes, describe what led to your career changes:

As a child, how difficult was it to make friends? (circle a number)

<u>Very Difficult</u>	<u>Somewhat Difficult</u>		<u>About Average</u>			<u>Somewhat Easy</u>	<u>Very Easy</u>		
1	2	3	4	5	6	7	8	9	10

As a child, how difficult was it to keep friends? (circle a number)

<u>Very Difficult</u>	<u>Somewhat Difficult</u>		<u>About Average</u>			<u>Somewhat Easy</u>	<u>Very Easy</u>		
1	2	3	4	5	6	7	8	9	10

About how many close friends did you have as a child? _____

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School/Occupational/Relationship History cont'd:

As an adolescent, how difficult was it to make friends? (circle a number)

<u>Very Difficult</u>	<u>Somewhat Difficult</u>	<u>About Average</u>	<u>Somewhat Easy</u>	<u>Very Easy</u>					
1	2	3	4	5	6	7	8	9	10

As an adolescent, how difficult was it to keep friends? (circle a number)

<u>Very Difficult</u>	<u>Somewhat Difficult</u>	<u>About Average</u>	<u>Somewhat Easy</u>	<u>Very Easy</u>					
1	2	3	4	5	6	7	8	9	10

About how many close friends did you have as an adolescent? _____

At what age did you start dating? _____

List the serious (long term, committed) relationships from your past that you think have had **the most impact** on you. Do not include ongoing committed relationships.

<u>First Name</u>	<u>His/her</u>	<u>Year became</u>	<u>Year moved in</u>	<u>Year married</u>	<u>Year separated</u>	<u>Year divorced</u>
	<u>Age now</u>	<u>couple</u>	<u>together</u>	<u>(if applicable)</u>	<u>or broke up</u>	<u>(if applicable)</u>

Is there any common pattern that seems to take place in many of your romantic involvements?

If Married or Cohabiting:

What year did you meet? _____

What did you like about him/her? _____

How long did you know each other before getting married/living together? _____

Thank you ! You have completed the assessment packet. This information will be kept confidential in accord with HIPPA regulations. Please sign below to indicate that you have completed this assessment packet.

Signature of patient/legal guardian

Date