BACKGROUND INFORMATION
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Please, **PRINT VERY CLEARLY (or type using a pdf editor)** and **place a footnote number with matching elaboration on a separate page** for any items you'd like to expand. If you scan and email the completed form to me 24 hours before your appointment, we'll not have to waste session time while I review it. "Marriage" & "Spouse" refer to any significant relationship or partner.

DATE OF FIRST APPOINTMENT_____

NAME_____BIRTHDATE_____AGE_____

PHONE #_____STREET/APT_____

CITY/STATE/ZIP_____ EMAIL_____

EMER.CONTACT_____RELATIONSHIP_____PHONE_____STATE_____

MARITAL STATUS_____JOB/PROFESSION_____ HIGHEST SCHOOL GRADE _____

FINANCIAL SITUATION σ terrible σ fair σ good σ very good ANY PRESENT LEGAL ISSUES σ yes σ no

MILITARY SERVICE σ yes (from_____to_____where_____) σ no

HAVE YOU EVER BEEN σ convicted σ imprisoned σ license suspended σ intentionally harmed an animal or person

DO ANY OF THESE DESCRIBE YOU: Actively Addicted/Abusing Alcohol, Drugs or Other Substances (excluding nicotine) • In Psychiatric Crisis • At Risk for Violent or Explosive Behavior • Have Acute Life-Threatening Disease or Eating Disorder • Ever Diagnosed With Borderline Personality Disorder • Requiring Documentation or Testimony Related to Disability, Workman's Compensation or Other Third Party or Litigation Claim σ YES (call me) σ UNSURE (call me) σ NO

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1. IN THE PAST MONTH Have you wished you were dead or wished you could go to sleep and not wake up? σ yes σ no
2. IN THE PAST MONTH Have you actually had any thoughts about killing yourself? σ yes σ no

IF YOU ANSWERED "YES" TO EITHER QUESTION, CONTINUE TO ANSWER #3, #4, #5 and #6
IF YOU ANSWERED "NO" TO BOTH QUESTIONS, GO DIRECTLY TO #6 and #7

3. Have you thought about how you might do this? σ yes σ no
4. Have you had any intention of acting on these thoughts, as opposed to having the thoughts but you definitely would not act on them? σ yes σ no
6. IN THE PAST 3 MONTHS Have you done anything, started to do anything, or prepared to do anything to end your life? (Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.) σ yes σ no
7. IN YOUR ENTIRE LIFETIME, how many times have you done any things like those mentioned in Question #6? _____

REASON(S) FOR SEEKING HELP_____

_____

REASON(S) FOR WHICH YOU PREVIOUSLY SOUGHT HELP (include year and for how long)_____

_____

_____

Have you ever received in-patient psychiatric care? σ yes (for what/year_____)σ no

CURRENT **PHYSICAL HEALTH** σ poor σ fair σ good σ very good σ excellent Height_____ Weight_____

MEDICAL CONDITIONS (include year of onset)_____

_____

_____

DATE OF LAST PHYSICAL EXAM_____ PRIMARY PHYSICIAN_____

UPCOMING MEDICAL TESTS OF CONCERN? σ yes σ no ALLERGIES_____

DESCRIBE YOUR **DIET**_____FREQ. & TYPE OF **EXERCISE**_____

ANY OF THE FOLLOWING: σ seizure σ brain injury σ stroke σ learning disability σ blackouts σ earlier alcohol/drug problem σ near death experience (year_____) σ afterlife contact with someone (year_____) σ memory/cognitive problem

MEDICATIONS (list name and what it isfor):_____

BIRTH CITY_____ CHILDHOOD CITY_____ #TIMES YOU MOVED BEFORE AGE 16____
DID YOU LEAVE BEFORE THE AGE OF 16 σ yes (why_____where to_____)σ no
FATHER σ living σ died (year____) σ abusive (σ sexual σ physical σ emotional) σ alcoholic σ drug abuse σ mental illness
HIS OCCUPATION_____ HIS EDUCATION_____
HOW DID HE TREAT YOU_____ WHAT DID YOU
LIKE ABOUT HIM_____DISLIKE ABOUT HIM_____
MOTHER σ living σ died (year____) σ abusive (σ sexual σ physical σ emotional) σ alcoholic σ drug abuse σ mental illness
HER OCCUPATION_____ HER EDUCATION_____
HOW DID SHE TREAT YOU_____ WHAT DID YOU
LIKE ABOUT HER_____DISLIKE ABOUT HER_____
What was your parents' marriage like? What did they fight about? How did their marriage impact your childhood?

SIBLINGS #older than you:_____ #younger than you:____ **OTHERS IN** HOUSEHOLD_____
TIMES ABUSED BY NON-PARENT (by whom_____) ___sexually ___physically ___emotionally
MOST RECENT YEAR ABUSED BY ANYONE_____ ARE YOU PRESENTLY IN DANGER OF ANY KIND σ yes σ no
AGE AT FIRST SEXUAL CONTACT_____ PREVIOUS MARRIAGES (Name, how long, year ended, reason)_____

NAME CURRENT **SPOUSE**_____ AGE____ RELATIONSHIP IS σ solid σ blah σ falling apart
IS FIDELITY AN ISSUE IN A PRESENT RELATIONSHIP σ yes σ no **PETS**_____
NAME/AGE EACH **CHILD**_____

YOUR 3 GREATEST **STRENGTHS** 1)_____2)_____3)_____
GREATEST ACHIEVEMENT_____ SOURCE OF SHAME_____
DESCRIBE **SPIRITUA**L BELIEFS (IF ANY)_____

HOBBIES_____HOURS. OF T.V. PER DAY_____ HOURS OF INTERNET PER DAY____
TIMES CANNABIS USE_____ PER σ day σ week σ month σ year σ RECREATIONAL σ MEDICAL
OF ALCOHOLIC DRINKS_____ PER σ day σ week σ month σ year OTHER RECREATIONAL DRUG USE σ yes σ no
ARE ANY OF THE FOLLOWING ADDICTIVE FOR YOU σ tobacco σ steroids σ gambling σ shopping σ internet or tv
σ porn σ hair pulling σ skin picking σ cutting/self injury σ eating σ binging or purging σ exercise σ sex σ other (_____)

DO YOU BELIEVE YOU ARE SUFFERING FROM PTSD (POST-TRAUMATIC DISTRESS DISORDER)? σ yes σ no
IF YES, DOES YOUR PTSD STEM FROM:
σ ONE OR MORE ***SINGLE, MOMENTARY*** EVENTS (such as sexual assault, accident, robbery, seeing something horrible)
Nature of event_____month/year it happened_____
Any additional single event_____month/year it happened_____
σ ON-GOING (REPEATED) EXPOSURE TO TRAUMA (such as incest, violence at home, etc)
Nature of event_____From (age)_____to_____

		Not at all	A little bit	Moderately	Quite a lot	Very much
In the past week....		0	1	2	3	4
1	How much have you been bothered by unwanted memories, nightmares or reminders of the event?	O	O	O	O	O
2	How much effort have you made to avoid thinking or talking about the event, or doing things which remind you of what happened?	O	O	O	O	O
3	To what extent have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?	O	O	O	O	O
4	How much have you been bothered by poor sleep, poor concentration, jumpiness, irritability	O	O	O	O	O

	or or feel watchful around you?					
5	How much have you been bothered by pain, aches, or tiredness?	O	O	O	O	O
6	How much would you get upset when stressful events or setbacks happen to you?	O	O	O	O	O
7	How much have the above symptoms interfered with your ability to work or carry out daily activities?	O	O	O	O	O
8	How much have the above symptoms interfered with your relationships with family or friends?	O	O	O	O	O

CHECK ANY SYMPTOMS YOU CURRENTLY HAVE σ acting out σ abnormal lack of energy σ angry outbursts σ loss of joy σ decreased appetite σ increased appetite σ concentration difficulty σ crying spells σ feelings of worthlessness σ increased worrying σ increased alcohol/substance use σ irritability σ isolation σ decreased sexual interest σ sadness σ sleep difficulty σ decreased sociability σ decreased activity WHEN DID SYMPTOMS BEGIN_____Have You Had Them Before σ yes (when_____) σ no

σ activity increase σ agitation σ distractability σ energy increase σ insomnia σ often irritable σ heightened sexual interest σ mood elevated σ racing thoughts σ risky activities σ heightened self-esteem σ sleep decrease σ sociability increase σ pressured speech σ overtalkative
WHEN DID SYMPTOMS BEGIN_____Have You Had Them Before σ yes (when_____) σ no

σ apprehensiveness σ avoidance σ chest pain σ chills/hot flashes σ choking sensation σ blushing σ confusion σ feeling distant from oneself σ world seems distant & unreal σ diarrhea σ difficulty concentrating σ embarrassment σ afraid of losing control σ increased heart rate σ hypervigilance σ often irritable σ muscular tension σ pins & needles σ phobias σ restlessness σ difficulty falling or staying asleep σ shortness of breath σ easily startled σ sweating σ shaking or trembling σ fear of dying σ worriment
WHEN DID SYMPTOMS BEGIN_____Have You Had Them Before σ yes (when_____) σ no

σ distressing reminders of earlier experience σ disturbing dreams σ flashbacks σ sense of foreshortened future σ recurrent recollections σ reluctance to express feeling σ memory issues σ others don't understand σ haunting memory
WHEN DID SYMPTOMS BEGIN_____Have You Had Them Before σ yes (when_____) σ no

σ unfounded jealousy σ feeling of being watched σ need to stay a step ahead σ I easily see hidden messages σ magic can solve problems σ voices sometimes guide me σ others have listened in on my thoughts σ more insightful than most σ often receiving signs σ I see truth where others don't σ others can take my thoughts σ not always sure what's real WHEN DID THESE THINGS START_____

BEFORE YOUR 18TH BIRTHDAY DID YOU OFTEN, OR VERY OFTEN FEEL THAT...

σ no one in your family loved you or thought you were important or special? OR your family didn't look out for each other, feel close to each other, or support each other?

σ an adult or person at least five years older than you touched or fondled you or had you touch their body in a sexual way? OR attempt or actually have oral, anal, or vaginal intercourse with you?

σ you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

σ a biological parent was lost to you through divorce, abandonment, or other reason?

σ your mother or stepmother often or very often was pushed, grabbed, slapped, or had something thrown at her? OR sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? OR ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

σ you lived with anyone who was a problem drinker or alcoholic, or who used street drugs?

σ a household member was depressed or mentally ill, or did a household member attempt suicide?

σ a household member went to prison?

ANYTHING ELSE ABOUT YOU, YOUR HISTORY, YOUR FEELINGS, YOUR HOPES-- ANYTHING AT ALL YOU'D LIKE ME TO KNOW?

ETT™ impacts the mind/body/spirit connection, therefore this information is very helpful when working on emotional issues even though it might, at first, seem irrelevent to psychotherapy. It's all connected.

1) On the chart, please put an S for surgery, an X for injury, along with the year for each.
2) Put an P anywhere you have chronic pain.