MN Couple Therapy Center
1611 County Road B, Suite 303
Roseville, MN 55113
651.340.4597

FULL NAME _____ DATE_____ DOB_____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? _____

_____

2. Did a specific event lead to this request for service? ☐ Yes ☐ No If yes, please describe the incident. _____

_____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy._____

_____

4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____

_____

6. How much does this problem affect your life? *(Please circle the number that best applies)*

	Not at all	**A Little bit**	**A lot**	**All the time**
1. Personally	1	2	3	4
2. Family life	1	2	3	4
3. Socially	1	2	3	4
4. Work	1	2	3	4
5. Health	1	2	3	4

7. How were you referred to this service? *(Please circle)*

Self Spouse/Other Physician Employer Court Other *(Please specify):* _____

8. Do you make use of any community-based support groups (e.g. 12-Step Programs, social support groups, etc)? ☐ Yes ☐ No

If yes, please specify: _____

9. Do you have an involvement with any of the following people or services? □ Yes □ No If yes, please circle all that apply:

County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum Worker's Compensation

If so, please describe. _____

Symptoms

10. Please look these items over and circle the number that best describes how these symptoms have bothered you **in the past two weeks**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11a. Thoughts of actually hurting yourself?	0	1	2	3	4	
	11b. Suicidal thoughts, plans, or attempts Have you ***ever*** thought about, planned or attempted suicide? Thought about ☐ YES ☐ NO Planned ☐ YES ☐ NO Attempted ☐ YES ☐ NO If yes to any of these, when was this? _____	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Contributing Factors

11. Which of the following do you think contribute to your problem(s)? *(Check all that apply)*

___ Family move to a new home
___ Adjustment to sitter/day care
___ Parental quarreling/arguing
___ Post-divorce adjustment
___ Financial stress
___ Marital unfaithfulness
___ Separation of parents
___ Remarriage of parent
___ Parenting problems
___ Spiritual problems
___ Death of a family member
___ Birth of child or sibling
___ Adjustment to school
___ School problems
___ Absenting home or school
___ Negative peer influence
___ Medical problems
___ Drugs or alcohol use
___ Career change
___ Previous therapy
___ Developmental problems
___ Suspect physical/sexual abuse
___ Known physical/sexual abuse
___ Law violations
___ Dishonesty
___ Work problems
___ Violence
___ Anger
___ Empty nest
___ Other:_____

Medical and Mental Health History

12. Who is your primary care physician and your primary clinic? _____

_____

13. Who else do you regularly see as part of your routine health care? _____

_____

14. List any significant health problems, past or present, including surgeries and/or illnesses with the ***corresponding dates***.

_____

_____

_____

15. Are you currently taking any medications? □ Yes □ No If yes, please list:

Medication	**Dose and number of pills you take per day** ***(e.g. .25 mg. 3 times per day)***	**Prescribing doctor**

16. Have you ever taken any other medications for depression, anxiety, or mental health issues? □ Yes □ No If yes, please list:

Medication Name	**Prescribed for? (eg: depression, anxiety)**	**When (approx)**	**How long were you on the medication?**	**Prescribing doctor**

17. List other therapy or counseling you have received in the past or are receiving now:

Therapist's name	**Location**	**Approximate dates**

18. What has been helpful in the past in therapy_____

What has **not** been helpful_____

19. If you think it would be helpful for your therapist to contact a previous therapist or physician, you will need to sign a Release of Information form.

20. Have you ever been hospitalized for mental health reasons? □ Yes □ No If yes, when and where? _____

Substance Use

21. Please describe your use of the following substances:

	Daily	**Weekly**	**Occasionally**	**In the past but not now**	**Not at all**
Caffeine					
Tobacco					
Alcohol					
Prescription drugs					
Inhalants					
Street drugs					
Over-the-counter medications					
Other: _____					

22. Have you ever had treatment for any type of alcohol or substance use? □ Yes □ No If yes, when? _____

Please describe: *(Include inpatient, outpatient, detox)*: _____

_____

Resources

23. What has helped you manage or endure your current problem? _____

_____

24. Who are the people in your life that currently play a supportive, influential, or friendship role. _____

_____

_____

25. What interests or passions give meaning to your life? _____

_____

26. Do you have any spiritual beliefs or practices that are important to you ? □ Yes □ No If yes, please explain: _____ __

_____

_____

27. What aspects of your culture, heritage, or ethnicity would you like your therapist to be aware of? _____

_____

Family Information

28. Please list those who you consider part of your immediate family and/or your current household.

Name	**Age**	**Relation to you**	**Living with you?**
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

Other

29. Is there anything else that you would like your therapist to know that you have not written about on any of these forms?

_____

_____

Signature and Date

I acknowledge that the information on this form is accurate to the best of my knowledge, and that I will inform my counselor of any changes in my personal information.

Client Signature _____ Date _____