

MN Couple Therapy Center
1611 County Road B, Suite 204
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)? If yes, please specify: _____

9. Do you have an involvement with any of the following people or services? 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	
V.	8. Avoiding situations that make you anxious?	0	1	2	3	4	
	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	
	11a. Thoughts of actually hurting yourself?	0	1	2	3	4	
VI.	11b. Suicidal thoughts, plans, or attempts Have you <i>ever</i> thought about, planned or attempted suicide? Thought about <input type="radio"/> YES <input type="radio"/> NO Planned <input type="radio"/> YES <input type="radio"/> NO Attempted <input type="radio"/> YES <input type="radio"/> NO If yes to any of these, when was this? _	0	1	2	3	4	
	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
VII.	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
VIII.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
IX.	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)*

- | | | |
|--|--|--|
| <input type="checkbox"/> Family move to a new home | <input type="checkbox"/> Death of a family member | <input type="checkbox"/> Developmental problems |
| <input type="checkbox"/> Adjustment to sitter/day care | <input type="checkbox"/> Birth of child or sibling | <input type="checkbox"/> Suspect physical/sexual abuse |
| <input type="checkbox"/> Parental quarreling/arguing | <input type="checkbox"/> Adjustment to school | <input type="checkbox"/> Known physical/sexual abuse |
| <input type="checkbox"/> Post-divorce adjustment | <input type="checkbox"/> School problems | <input type="checkbox"/> Law violations |
| <input type="checkbox"/> Financial stress | <input type="checkbox"/> Absenting home or school | <input type="checkbox"/> Dishonesty |
| <input type="checkbox"/> Marital unfaithfulness | <input type="checkbox"/> Negative peer influence | <input type="checkbox"/> Work problems |
| <input type="checkbox"/> Separation of parents | <input type="checkbox"/> Medical problems | <input type="checkbox"/> Violence |
| <input type="checkbox"/> Remarriage of parent | <input type="checkbox"/> Drugs or alcohol use | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Parenting problems | <input type="checkbox"/> Career change | <input type="checkbox"/> Empty nest |
| <input type="checkbox"/> Spiritual problems | <input type="checkbox"/> Previous therapy | <input type="checkbox"/> 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? **No**

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

16. Have you ever taken any other medications for depression, anxiety, or mental health issues? **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?

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 ? _____

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?
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> No
			<input type="radio"/> Yes <input type="radio"/> 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