CLINICAL QUESTIONNAIRE

(one questionnaire for each spouse)

This questionnaire is designed to supply your therapist with comprehensive information about your past history and present situation. By completing these questions as fully and accurately as you can, you will facilitate your clinical assessment and therapy program. Thank you.

1. General Information:

Date:________________

Name:_____________________________________ Spouse name:____________________

Address: ____Sex: ☐Male ☐Female

____ Age:________ Date of Birth: ___________

Phone number____________________ ☐Home ☐Cell ☐Work

Phone number____________________ ☐Home ☐Cell ☐Work

Marital Status (please check one of the following):

☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Remarried ☐ Living together ☐ Widowed

Do you have any children? Yes____ No_____

If so, please list names and ages below:

NAME:	AGE:	/	NAME:	AGE:
____________________	______	/	___________________	_____
____________________	______	/	____________________	_____
____________________	______	/	____________________	_____
____________________	______	/	____________________	_____

Primary Care Physician (PCP): ______________________________

Address: ____

Health Insurance: ____

2. Current Clinical Data:

(a.) Describe the main problem(s) that led you to seek therapy at this time, including the duration of this problem (or set of problems):

(b.) Briefly describe the history of this problem, or set of problems, including a list of stress factors which seem to be triggering and/or intensifying the problem now:

(c.) Circle the degree to which you have been experiencing each of the following <u>Moods, Emotions and Feelings</u> as a result of the problem(s) that led you to seek therapy:

	Not at all	To only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Angry	0	1	2	3
2. Panicky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10. Lonely	0	1	2	3
11. Resentful	0	1	2	3
12. Dependent	0	1	2	3
13. Confused	0	1	2	3
14. Guilty	0	1	2	3
15. Nervous	0	1	2	3
16. Listless	0	1	2	3
17. Hopeless	0	1	2	3
18. Tense	0	1	2	3
19. Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21. Terrified	0	1	2	3
22. Embarrassed	0	1	2	3
23. Elated	0	1	2	3
24. Abandoned	0	1	2	3
25. Agitated	0	1	2	3
26. Worried	0	1	2	3
27. Helpless	0	1	2	3
28. Grief	0	1	2	3

Other emotional reactions:

____

____

____

Circle how often you have been bothered by each of the following <u>Difficulties with Thinking</u> since the problem(s) that led you to seek therapy began:

	Never	Occasionally	Often
1. Concentration difficulties	0	1	2
2. Difficulty remembering things	0	1	2
3. Your mind going "blank"	0	1	2
4. Difficulty making decisions	0	1	2
5. Difficulty making sound judgments	0	1	2
6. Distractible	0	1	2
7. Thoughts are "racing"	0	1	2
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2
9. Repetitive thought(s), image(s), or urge(s)	0	1	2
10. Suicidal thoughts	0	1	2
11. Thoughts of killing someone	0	1	2
12. Preoccupation with death	0	1	2

Other problems not listed above:

____

____

____

Circle how much you have been distressed or bothered by each of the following <u>Physical Reactions</u> since the onset of the problem(s) that led you to seek therapy:

	Not at All or Only a Minimal Degree	To a Moderate Degree	To a Very Strong Degree
1. Shortness of breath or smothering sensations	0	1	2
2. Nausea, diarrhea, or other abdominal stresses	0	1	2
3. Trouble swallowing or “lump in throat”	0	1	2
4. Muscle tension, aches, or soreness	0	1	2
5. Flushes (not flashes) or chills	0	1	2
6. Dizziness or light-headed	0	1	2
7. Trouble falling or staying asleep	0	1	2
8. Sweating or cold clammy hands	0	1	2
9. Fatigue or loss of energy	0	1	2
10. Decrease in appetite	0	1	2
11. Weight loss	0	1	2
12. Decreased need for sleep	0	1	2
13. Numbness or tingling sensations	0	1	2
14. Weepiness/crying	0	1	2
15. Palpitations or accelerated heart rate	0	1	2
16. Headaches	0	1	2
17. Increase in appetite	0	1	2
18. Weight gain	0	1	2
19. Increased need for sleep	0	1	2
20. Chest pains or discomfort	0	1	2
21. Physical problems (for example, impaired physical functioning, physical pain, etc.)	0	1	2
22. Awakening earlier in the morning than you normally do.	0	1	2

Other physical reactions:____

____

____

Circle the degree to which you have been experiencing each of the following additional reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feelings like you want to beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)	0	1	2	3
14. Increased alcohol use	0	1	2	3
15. Use of “street” (non-prescription) drugs	0	1	2	3

Any other effects or reactions; stemming from your problem(s), not described above:

____

____

(d.) Family Functioning: Briefly describe how *the problems you are having*, have been affecting your relationship with family members (i.e. spouse, partner, children and other significant relatives):

(e.) Social Functioning: Briefly describe how *the problems you are having*, have been affecting your social functioning with non-family members (i.e. relationship with friends):

(f.) Work/ School Functioning: Briefly describe any ways that you feel your functioning at work and, if relevant, at school, has been affected by *your current problem(s)* (i.e. performance levels, relationship with co-workers)

(g.) Please place a checkmark in the appropriate box for each of the following

Have you ever:	**Present**	**Past**	**Future**
1. Purposely injured yourself without suicidal intent (e.g. cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g. friend, family, partner, or authority figure) with cruel or malicious intent			
9. Been involved in child abuse a.) as a victim/survivor b.) as a perpetrator			
10. Been involved in sexual abuse a.) as a victim/survivor b.) as a perpetrator			
11. Had an eating disorder			
12. Felt that something was wrong with your mind			
13. Physically threatened another person			
14. Assaulted or attempted to kill another person			
15. Felt your thoughts were so loud people could hear them			
16. Had periods of time you can't account for			
17. Had periods of severe depression			
18. Believed others were conspiring against you			
19. Had periods in which you felt extremely optimistic, full of energy, could get by on little or no sleep, and/or thought and talked very fast			
20. Felt compelled to help other people			
21. Felt compelled to isolate yourself			

(h.) Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours	Used in Last 6 Months
Alcohol					Y N	Y N
Nicotine					Y N	Y N
Marijuana					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N

If you have used alcohol:

1. Have you ever tried to cut down on your drinking? ☐Yes ☐No
2. Have you ever been annoyed at other's complaints about your drinking? ☐Yes ☐No
3. Have you ever felt guilty about your drinking? ☐Yes ☐No
4. Have you ever taken a morning "eye opener" (drink)? ☐Yes ☐No

Are there particular situations in which drug or alcohol use tends to occur? ☐Yes ☐No

If Yes, please describe:

Is your current use of alcohol and/or drugs causing or contributing to problems in any aspect of your functioning (relationship with others, functioning at work or school, etc,)?

☐Yes ☐No

If yes, describe the nature of the problem(s) stemming from your current use of alcohol and/or drugs:

3. Historical Clinical Data

a.) Have you had any previous issues for which you feel a mental health professional should have been seen, or for which you actually did seek professional help? ☐Yes ☐No

If yes, state the issue(s):

Did you receive professional help for these issues: ☐Yes ☐No

If you were seen as an *outpatient*, indicate when and where you were seen and the name(s) of the professional(s) with whom you were in treatment:

If you were seen as an *inpatient*, indicate where you were hospitalized, and the name(s) of the professional(s) with whom you were in treatment:

(b.) If you have received professional help for alcohol or substance abuse problems, indicate when and where you received treatment, and the name of your primary counselor or therapist:

(c.) Is there any family history of alcohol or drug problems, and/or problems of a psychiatric nature? ☐Yes ☐No

If yes, describe the nature of these problems:

5. *Family Data*

(a.) Father:
If alive, his present age:_________
If deceased, your age and his age at his time of death:(your age/his age)____________
Cause of death: ____
Occupation: ____
How would you describe your father, and how did you get along with him?

(b.) Mother
If alive, her present age:_________
If deceased, your age and her age at her time of death:(your age/her age)___________
Cause of death: ____
Occupation: ____
How would you describe your mother, and how did you get along with her?

Brothers and Sisters:

Name	Age	How did/do you get along with him/her

(c.) Were you adopted as a child? ☐Yes ☐No

(d.) Were you diagnosed as a hyperactive child? ☐Yes ☐No

(e.) Were your parents separated or divorced as a child? ☐Yes ☐No

(f.) Were either of your parents seriously physically ill and/or absent for long periods of time during your growing up years? ☐Yes ☐No

(g.) Briefly describe any experiences that you had while growing up that you believe may have a bearing on your present problem(s):

(h.) Spouse/Partner Name:_______________________________________ Age_________

Occupation__________________________________ Years married_________________

How would you describe your spouse or partner, and how do you get along with him or her?

If divorced/divorcing, reason for divorce?

(i.) Repeat the above for 2nd spouse:

6. Social/Educational/Employment/Legal Data

(a.) Briefly describe any aspects of your social history, other than in your family of origin, which you believe may have a bearing on your present problem(s):

(b.) Indicate the highest level of formal education that you have obtained:

(c.) Briefly describe any experiences relating to school that you think may have a bearing on your present problem(s):

(d.) Indicate your current occupation:____

(e.) How many times have you changed jobs in the last 5 years?___________________

(f.) Are you a combat veteran? ☐Yes ☐No
If yes, which War(s):

(g.) Have you had any problems of a legal nature (including arrests)? ☐Yes ☐No
If yes, briefly describe what this involved:

7. ***Medical Data***

(a.) If you have had any past or current medical illnesses, surgeries, or traumas, give a brief description of these, including when they occurred:

Dates	Incident	Treating Physician

(b.) List any current medications, including dosage, that you take:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	

(c.) Indicate any allergies that you have:

(d.) The date of your last physical:___________________________________

CLINICAL QUESTIONNAIRE

(one questionnaire for each spouse)

This questionnaire is designed to supply your therapist with comprehensive information about your past history and present situation. By completing these questions as fully and accurately as you can, you will facilitate your clinical assessment and therapy program. Thank you.

***1. General Information*:** Date:________________

Name:____________________________________ Spouse name:___________________

Address: ____ Sex: ☐Male ☐Female

____ Age:________ Date of Birth: __________

Phone number____________________ ☐Home ☐Cell ☐Work

Phone number____________________ ☐Home ☐Cell ☐Work

Marital Status (please check one of the following):

☐ Single ☐ Engaged ☐ Married ☐ Divorced ☐ Remarried ☐ Living together ☐ Widowed

Do you have any children? Yes____ No_____

If so, please list names and ages below:

NAME:	AGE:	/	NAME:	AGE:
____________________	______	/	___________________	_____
____________________	______	/	____________________	_____
____________________	______	/	____________________	_____
____________________	______	/	____________________	_____

Primary Care Physician (PCP): ______________________________

Address: ____

Health Insurance:____

2. Current Clinical Data:

(a.) Describe the main problem(s) that led you to seek therapy at this time, including the duration of this problem (or set of problems):

(b.) Briefly describe the history of this problem, or set of problems, including a list of stress factors which seem to be triggering and/or intensifying the problem now:

(c.) Circle the degree to which you have been experiencing each of the following Moods, Emotions and Feelings as a result of the problem(s) that led you to seek therapy:

	Not at all	To only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Angry	0	1	2	3
2. Panicky	0	1	2	3
3. Depressed	0	1	2	3
4. Ashamed	0	1	2	3
5. Bored	0	1	2	3
6. Irritable	0	1	2	3
7. Fearful	0	1	2	3
8. Suspicious	0	1	2	3
9. Empty	0	1	2	3
10. Lonely	0	1	2	3
11. Resentful	0	1	2	3
12. Dependent	0	1	2	3
13. Confused	0	1	2	3
14. Guilty	0	1	2	3
15. Nervous	0	1	2	3
16. Listless	0	1	2	3
17. Hopeless	0	1	2	3
18. Tense	0	1	2	3
19. Sad	0	1	2	3
20. Mistrustful	0	1	2	3
21. Terrified	0	1	2	3
22. Embarrassed	0	1	2	3
23. Elated	0	1	2	3
24. Abandoned	0	1	2	3
25. Agitated	0	1	2	3
26. Worried	0	1	2	3
27. Helpless	0	1	2	3
28. Grief	0	1	2	3

Other emotional reactions:

____

____

____

Circle how often you have been bothered by each of the following Difficulties with Thinking since the problem(s) that led you to seek therapy began:

	Never	Occasionally	Often
1. Concentration difficulties	0	1	2
2. Difficulty remembering things	0	1	2
3. Your mind going "blank"	0	1	2
4. Difficulty making decisions	0	1	2
5. Difficulty making sound judgments	0	1	2
6. Distractible	0	1	2
7. Thoughts are "racing"	0	1	2
8. Unwanted and/or intrusive thought(s), image(s), or urge(s)	0	1	2
9. Repetitive thought(s), image(s), or urge(s)	0	1	2
10. Suicidal thoughts	0	1	2
11. Thoughts of killing someone	0	1	2
12. Preoccupation with death	0	1	2

Other problems not listed above:

____

____

____

Circle how much you have been distressed or bothered by each of the following Physical Reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All or Only a Minimal Degree	To a Moderate Degree	To a Very Strong Degree
1. Shortness of breath or smothering sensations	0	1	2
2. Nausea, diarrhea, or other abdominal stresses	0	1	2
3. Trouble swallowing or “lump in throat”	0	1	2
4. Muscle tension, aches, or soreness	0	1	2
5. Flushes (not flashes) or chills	0	1	2
6. Dizziness or light-headed	0	1	2
7. Trouble falling or staying asleep	0	1	2
8. Sweating or cold clammy hands	0	1	2
9. Fatigue or loss of energy	0	1	2
10. Decrease in appetite	0	1	2
11. Weight loss	0	1	2
12. Decreased need for sleep	0	1	2
13. Numbness or tingling sensations	0	1	2
14. Weepiness/crying	0	1	2
15. Palpitations or accelerated heart rate	0	1	2
16. Headaches	0	1	2
17. Increase in appetite	0	1	2
18. Weight gain	0	1	2
19. Increased need for sleep	0	1	2
20. Chest pains or discomfort	0	1	2
21. Physical problems (for example, impaired physical functioning, physical pain, etc.)	0	1	2
22. Awakening earlier in the morning than you normally do.	0	1	2

Other physical reactions:____
____
____

Circle the degree to which you have been experiencing each of the following additional reactions since the onset of the problem(s) that led you to seek therapy:

	Not at All	To Only a Mild Degree	To a Moderate Degree	To a Very Strong Degree
1. Feeling as if things were not real	0	1	2	3
2. Feeling little or no interest in things	0	1	2	3
3. Feeling little or no pleasure from activities	0	1	2	3
4. Having nightmares or distressing dreams	0	1	2	3
5. Problems with sexual functioning	0	1	2	3
6. Feeling detached from (as if an observer of) your own mental processes or body	0	1	2	3
7. Feelings of inadequacy or worthlessness	0	1	2	3
8. Feelings like you want to beat or harm someone	0	1	2	3
9. Wanting to avoid certain things, places, people, or activities	0	1	2	3
10. Social withdrawal	0	1	2	3
11. Temper outbursts	0	1	2	3
12. Excessively checking things, counting things, washing, or other repetitive action(s) that you feel you must perform	0	1	2	3
13. Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)	0	1	2	3
14. Increased alcohol use	0	1	2	3
15. Use of “street” (non-prescription) drugs	0	1	2	3

Any other effects or reactions; stemming from your problem(s), not described above:
____
____

(d.) Family Functioning: Briefly describe how *the problems you are having*, have been affecting your relationship with family members (i.e. spouse, partner, children and other significant relatives):

(e.) Social Functioning: Briefly describe how *the problems you are having*, have been affecting your social functioning with non-family members (i.e. relationship with friends):

(f.) Work/ School Functioning: Briefly describe any ways that you feel your functioning at work and, if relevant, at school, has been affected by *your current problem(s*) (i.e. performance levels, relationship with co-workers)

(g.) Please place a checkmark in the appropriate box for each of the following

Have you ever:	**Present**	**Past**	**Future**
1. Purposely injured yourself without suicidal intent (e.g. cut, hit, burned, etc.)			
2. Seriously considered attempting suicide			
3. Made a suicide attempt			
4. Considered seriously injuring another person			
5. Intentionally caused serious injury to another person			
6. Had unwanted sexual contact(s) or experience(s)			
7. Experienced harassing, controlling, and/or abusive behavior from another person (e.g., friend, family member, partner, or authority figure)			
8. Been hit, punched, slapped, kicked, or otherwise physically harmed by a person (e.g. friend, family, partner, or authority figure) with cruel or malicious intent			
9. Been involved in child abuse a.) as a victim/survivor b.) as a perpetrator			
10. Been involved in sexual abuse a.) as a victim/survivor b.) as a perpetrator			
11. Had an eating disorder			
12. Felt that something was wrong with your mind			
13. Physically threatened another person			
14. Assaulted or attempted to kill another person			
15. Felt your thoughts were so loud people could hear them			
16. Had periods of time you can't account for			
17. Had periods of severe depression			
18. Believed others were conspiring against you			
19. Had periods in which you felt extremely optimistic, full of energy, could get by on little or no sleep, and/or thought and talked very fast			
20. Felt compelled to help other people			
21. Felt compelled to isolate yourself			

(h.) Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used in Last 48 Hours	Used in Last 6 Months
Alcohol					Y N	Y N
Nicotine					Y N	Y N
Marijuana					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N
Other (fill in):					Y N	Y N

If you have used alcohol:

1. Have you ever tried to cut down on your drinking? ☐Yes ☐No
2. Have you ever been annoyed at other's complaints about your drinking? ☐Yes ☐No
3. Have you ever felt guilty about your drinking? ☐Yes ☐No
4. Have you ever taken a morning "eye opener" (drink)? ☐Yes ☐No

Are there particular situations in which drug or alcohol use tends to occur? ☐Yes ☐No

If Yes, please describe:

Is your current use of alcohol and/or drugs causing or contributing to problems in any aspect of your functioning (relationship with others, functioning at work or school, etc,)?

☐Yes ☐No

If yes, describe the nature of the problem(s) stemming from your current use of alcohol and/or drugs:

3. Historical Clinical Data

a.) Have you had any previous issues for which you feel a mental health professional should have been seen, or for which you actually did seek professional help? ☐Yes ☐No

If yes, state the issue(s):

Did you receive professional help for these issues: ☐Yes ☐No

If you were seen as an *outpatient*, indicate when and where you were seen and the name(s) of the professional(s) with whom you were in treatment:

If you were seen as an *inpatient*, indicate where you were hospitalized, and the name(s) of the professional(s) with whom you were in treatment:

(b.) If you have received professional help for alcohol or substance abuse problems, indicate when and where you received treatment, and the name of your primary counselor or therapist:

(c.) Is there any family history of alcohol or drug problems, and/or problems of a psychiatric nature? ☐Yes ☐No

If yes, describe the nature of these problems:

5. ***Family Data***

(a.) Father:

If alive, his present age:_________

If deceased, your age and his age at his time of death:(your age/his age)____________

Cause of death: ____

Occupation: ____

How would you describe your father, and how did you get along with him?

(b.) Mother

If alive, her present age:_________

If deceased, your age and her age at her time of death:(your age/her age)___________

Cause of death: ____

Occupation: ____

How would you describe your mother, and how did you get along with her?

Brothers and Sisters:

Name	Age	How did/do you get along with him/her

(c.) Were you adopted as a child? ☐Yes ☐No

(d.) Were you diagnosed as a hyperactive child? ☐Yes ☐No

(e.) Were your parents separated or divorced as a child? ☐Yes ☐No

(f.) Were either of your parents seriously physically ill and/or absent for long periods of time during your growing up years? ☐Yes ☐No

(g.) Briefly describe any experiences that you had while growing up that you believe may have a bearing on your present problem(s):

(h.) Spouse/Partner Name:_______________________________________ Age_________

Occupation__________________________________ Years married_________________

How would you describe your spouse or partner, and how do you get along with him or her?

If divorced/divorcing, reason for divorce?

(i.) Repeat the above for 2nd spouse:

6. Social/Educational/Employment/Legal Data

(a.) Briefly describe any aspects of your social history, other than in your family of origin, which you believe may have a bearing on your present problem(s):

(b.) Indicate the highest level of formal education that you have obtained:

(c.) Briefly describe any experiences relating to school that you think may have a bearing on your present problem(s):

(d.) Indicate your current occupation:____

(e.) How many times have you changed jobs in the last 5 years?___________________

(f.) Are you a combat veteran? ☐Yes ☐No

If yes, which War(s):

(g.) Have you had any problems of a legal nature (including arrests)? ☐Yes ☐No

If yes, briefly describe what this involved:

7. *Medical Data*

(a.) If you have had any past or current medical illnesses, surgeries, or traumas, give a brief description of these, including when they occurred:

Dates	Incident	Treating Physician

(b.) List any current medications, including dosage, that you take:

Medication	Dosage	Reason Taken	# of times of day taken	# of days a week taken	Prescribing Physician
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	
				7 Days As Needed Other: _____	

(c.) Indicate any allergies that you have:

(d.) The date of your last physical: ___________________________________