

Reasons: _____

(c) Annual Family Income:

\$0 to 10,000	_____	\$30,000 to 35,000	_____
10,000 to 15,000	_____	35,000 to 40,000	_____
15,000 to 20,000	_____	40,000 to 45,000	_____
20,000 to 25,000	_____	45,000 to 50,000	_____
25,000 to 30,000	_____	50,000 or above	_____

(d) Financially Stable: Yes _____ No _____

(e) Health Insurance? Yes _____ No _____ Company: _____

(f) **Mother:** Name _____ Age: _____

Father: Name _____ Age: _____

Occupation: (M) _____ (F) _____

Mother Deceased? _____ Date: _____ Father Deceased? _____ Date: _____

(g) Siblings: Brothers (how many?) _____ Ages: _____

Sisters (how many?) _____ Ages: _____

3. PHYSICAL

Height _____ Weight _____ Current Medication(s) _____

Are you pregnant? Yes _____ No _____ Due date: _____

Do you have any current physical health problems? If so, please specify: _____

Do you have any handicaps? No _____ Yes _____

Do you wear contacts or glasses? No _____ Yes _____

Do you have eye problems? No _____ Yes _____

Do you have epilepsy? No _____ Yes _____

Do you have any disability? No _____ Yes _____

Have you ever had any head injuries or loss of consciousness? If so, please give details: _____

Type of injury: _____ Date: _____

Check any of the following that **often** apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tics | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Burning or itching skin |
| <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Twitches | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Back pain | <input type="checkbox"/> Rapid heart beat |
| <input type="checkbox"/> Sexual disturbances | <input type="checkbox"/> Tremors | <input type="checkbox"/> Don't like being touched |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hear things | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Visual disturbance |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Flushes | <input type="checkbox"/> Loss of memory |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lump in throat | <input type="checkbox"/> Sighing |
| <input type="checkbox"/> Hearing problem | | |

Please list any medications you have taken during the past six months (including aspirin, birth control pills, or any medicines that were prescribed or taken over the counter): _____

Check any of the following that have applied to you in the past month:

DRUGS

Never Rarely Occasionally Frequently

Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				

Never Rarely Occasionally Frequently

Alcohol				
Caffeine				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc.)				

SYMPTOMS

Allergies				
Ulcers				
Heartburn				
High blood pressure				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Early morning awakening				
Fitful sleep				
Overeating				
Poor appetite				

4. BEHAVIOR AND FEELINGS

Check any that have been a serious experience for you:

- | | | |
|---|--|---|
| <input type="checkbox"/> Learning problems (lately) | <input type="checkbox"/> Problems with friends | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Physical abuse | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Unhappy childhood | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Physical problems | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Rage |
| <input type="checkbox"/> Behavior problems | <input type="checkbox"/> Sexual abuse | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Family problems | <input type="checkbox"/> Rape | <input type="checkbox"/> Sexual issues |
| <input type="checkbox"/> Eating disorders | | |

Check any of the following behaviors that have applied to you in the past month:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Crying | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Concentration difficulties | <input type="checkbox"/> Temper outbursts | <input type="checkbox"/> Withdrawal |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Working too hard | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Loss of control | <input type="checkbox"/> Compulsions |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Nervous tics | <input type="checkbox"/> Risk taking |
| <input type="checkbox"/> Impulsive actions | <input type="checkbox"/> Procrastination | <input type="checkbox"/> Laziness |
| <input type="checkbox"/> Phobic avoidance | | |

Check any of the following feelings that often apply to you:

- | | | |
|---------------------------------------|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Angry | <input type="checkbox"/> Guilty | <input type="checkbox"/> Unhappy |
| <input type="checkbox"/> Annoyed | <input type="checkbox"/> Happy | <input type="checkbox"/> Bored |
| <input type="checkbox"/> Sad | <input type="checkbox"/> Conflicted | <input type="checkbox"/> Restless |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Regretful | <input type="checkbox"/> Lonely |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Hopeless | <input type="checkbox"/> Contented |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Hopeful | <input type="checkbox"/> Excited |
| <input type="checkbox"/> Panicky | <input type="checkbox"/> Helpless | <input type="checkbox"/> Optimistic |
| <input type="checkbox"/> Energetic | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Envy | <input type="checkbox"/> Jealous | |
| <input type="checkbox"/> Other: _____ | | |

(a) Have you ever been hospitalized for psychological problems? Yes _____ No _____

If so, when and where? _____

(b) Have you ever attempted suicide? Yes _____ No _____ Number of times: _____

(c) List your main fears:

- 1.
- 2.
- 3.

5. DESCRIPTION OF TRAUMATIC MEMORY

What is the traumatic memory about? Does it continue to interfere with your life? How? _____

When did your trauma occur (date)? _____

Have you been in therapy before or received any prior help for your trauma? If so, please give name(s), professional title(s), date(s) of treatment(s) and results:

Names	Date(s)	No Improvement (check)
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In case of an emergency, contact:

Name	Relationship to you	Phone number
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