Embody Your Life, LLC
Embody*Awaken*Transform

PLEASE BRING THIS QUESTIONNAIRE TO YOUR FIRST APPOINTMENT.

To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. Answer all that apply ONLY.

Personal History

Name: _____ Age: _____Gender: ____ M ____ F ____ Other/Non-binary

Address:_____ City: _____ State: _____ Zip: _____

Today's date: _____ Date of birth and Current Age: _____

Home phone: _____ Mobile phone: _____

Counseling History

Are you receiving OUTPATIENT counseling services at present? Yes No

If Yes, please briefly describe: _____

_____

Have you received OUTPATIENT counseling in the past? Yes No

If Yes, please briefly describe: _____

_____

What is (are) your main reason(s) for this visit? _____

_____

_____

How long has this problem persisted? _____

_____

_____

Under what conditions do your problems usually get worse? _____

_____

_____

Under what conditions are your problems usually improved? _____

_____

_____

How did you hear about me, or who referred you? _____

_____

_____

Name and address of your primary psychiatrist, if applicable:

Physician's name: _____

Address: _____

List any major illnesses and/or surgeries you have had, including as an infant: _____

_____

_____

List any physical concerns you are having at present (e.g., high blood pressure, headaches, dizziness, etc.):

_____

_____

List any other physical concerns you are having at present: _____

_____

_____

When was your most recent complete physical exam? _____

Results of physical exam: _____

_____

On average how many hours of sleep do you get daily? _____

Do you have trouble falling asleep at night, staying asleep or do you wake up prematurely? Yes / No

If Yes, describe: _____

_____

Describe your appetite (during the past week):

____ poor appetite ___ average appetite ___ large appetite

What medications (and dosages) are you taking at present, and for what purpose?

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____

Self-harm

Do you have suicidal thoughts? ____ yes _____ no

Have you ever attempted suicide? ____ yes _____ no

If yes, how and when? _____

Do you engage in any other self-harming behaviors (e.g. cutting, burning, picking)? ____ yes _____ no

Can you commit to safety while under my care? ____ yes _____ no

Thoughts and Behaviors

Please check how often the following thoughts occur to you:

1)	Life is hopeless.	___ Never	___ Rarely	___ Sometimes	___ Frequently
2)	I am lonely.	___ Never	___ Rarely	___ Sometimes	___ Frequently
3)	No one cares about me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
4)	I am a failure.	___ Never	___ Rarely	___ Sometimes	___ Frequently
5)	Most people don't like me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
6)	I want to die.	___ Never	___ Rarely	___ Sometimes	___ Frequently
7)	I want to hurt someone.	___ Never	___ Rarely	___ Sometimes	___ Frequently
8)	I am so stupid.	___ Never	___ Rarely	___ Sometimes	___ Frequently
9)	I am going crazy.	___ Never	___ Rarely	___ Sometimes	___ Frequently
10)	I can't concentrate.	___ Never	___ Rarely	___ Sometimes	___ Frequently
11)	I am so depressed.	___ Never	___ Rarely	___ Sometimes	___ Frequently
12)	God is disappointed in me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
13)	I can't be forgiven.	___ Never	___ Rarely	___ Sometimes	___ Frequently
14)	Why am I so different?	___ Never	___ Rarely	___ Sometimes	___ Frequently
15)	I can't do anything right.	___ Never	___ Rarely	___ Sometimes	___ Frequently
16)	People hear my thoughts.	___ Never	___ Rarely	___ Sometimes	___ Frequently
17)	I have no emotions.	___ Never	___ Rarely	___ Sometimes	___ Frequently
18)	Someone is watching me.	___ Never	___ Rarely	___ Sometimes	___ Frequently
19)	I hear voices in my head.	___ Never	___ Rarely	___ Sometimes	___ Frequently
20)	I am out of control.	___ Never	___ Rarely	___ Sometimes	___ Frequently

Symptoms

70) Check the behaviors and symptoms that occur to you more often than you would like them to take place:

____ aggression	____ fatigue	____ sexual difficulties
____ alcohol dependence	____ hallucinations	____ sick often
____ anger	____ heart palpitations	____ sleeping problems
____ antisocial behavior	____ high blood pressure	____ speech problems
____ anxiety	____ hopelessness	____ suicidal thoughts
____ avoiding people	____ impulsivity	____ rapid thoughts
____ chest pain	____ irritability	____ trembling
____ depression	____ judgment errors	____ withdrawing
____ disorientation	____ loneliness	____ worrying
____ distractibility	____ memory impairment	____ other (specify)
____ dizziness	____ mood shifts	_____
____ drug dependence	____ panic attacks	_____
____ eating disorder	____ phobias/fears	_____
____ elevated mood	____ recurring thoughts	_____

Please give examples of how each of the symptoms you checked impairs your ability to function (e.g., socially, emotionally, occupationally, physically). Use the back of this sheet if necessary.

List your five greatest strengths:

1) _____
2) _____
3) _____
4) _____
5) _____

List your five greatest weaknesses:

1) _____
2) _____
3) _____
4) _____
5) _____

List your main social difficulties: _____

List your main love and sex difficulties: _____

List your main difficulties at school or work: _____

List your main difficulties at home: _____

_____

_____

_____

_____

_____

Have you been in intensive treatment before? When? Where? At what level of care (intensive outpatient, partial-hospitalization, day treatment, residential, hospital)

_____

_____

_____

List dates and effects of previous treatment experiences:

_____

_____

What was most helpful, least helpful about previous treatments?

_____

_____

Current living and social environment

Who you live with? _____

How do you feel about your current living environment?

_____

_____

Who is in your support system (e.g., family, friends, teachers)? List them by name and rank them by importance (who would you go to first?):

_____

_____

_____

Are there any activities or hobbies that help you cope and reduce your use of symptoms? How do you express yourself creatively? What aspects of your life give you the most pleasure?

_____

_____

_____

What are some of your current stressors?_____

_____

_____

_____

List your behaviors you would like to change: _____

_____

_____

_____

What is the <u>one problem</u>, or <u>one behavior</u>, you really want to resolve in therapy in the next 3-6 months?

_____

_____

_____

Please rate your willingness to change those behaviors you listed above:

Not willing at all — Average — Extremely willing

1 2 3 4 5 6 7 8 9 10

Please rate how capable you feel to change those behaviors you listed above:

Not at all capable — Average — Extremely capable

1 2 3 4 5 6 7 8 9 10

How will we measure progress to know we are moving in the right direction?

_____

_____

<u>Trauma</u>

Does anyone in your family struggle with a substance abuse, mental health or eating disorder problem? _____ yes _____ no

Have you been verbally, emotionally or physically abused? _____ yes _____ no

Have you been sexually abused? _____ yes _____ no

Have you had any major losses? _____ yes _____ no

List your trauma timeline below by age group, trauma being any critically overwhelming event and next to it the resources (people, places, things or personal inner qualities) that helped you cope (use the back of this form or additional form if needed):

Ages	Overwhelming Event	Resources
Pre-natal or birth		
0-5 years		
6-10 years		
11-15 years		
16-24 years		
25-35 years		
36-64		
65 and above		

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