



**UNIVERSITY OF  
PENNSYLVANIA  
HEALTH SYSTEM**

**Department of Psychiatry  
Center for Cognitive Therapy**

This file is comprised of the forms that you can print out and complete prior to your initial diagnostic evaluation here at the Center for Cognitive Therapy. It is very important that you fill them out in their entirety and bring them with you when you come in for your evaluation. If you have any questions, please feel free to contact Tina Inforzato at 215-898-4118, or Dr. Cory F. Newman at 215-898-3466. We look forward to being of assistance to you.

### **OUR LOCATION**

The Center for Cognitive Therapy is located on the northeast corner of 36<sup>th</sup> and Market Street, at 3535 Market Street on the 2<sup>nd</sup> Floor. We are within the Penn Behavioral Health suite, and the check-in office is Room 2046 (Tina Inforzato), which is down the hall to the left after you walk through the waiting area. For further directions, please consult the following web address:

[http://pennhealth.com/hup/vi\\_files/d\\_t\\_p.html#3535](http://pennhealth.com/hup/vi_files/d_t_p.html#3535)

Thank you,

The therapists and staff of the Center for Cognitive Therapy



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Center for Cognitive Therapy

I would like to tell you a few important points about the Center for Cognitive Therapy and its policies.

The Center for Cognitive Therapy is a treatment and training center. Your initial appointment at the Center is a two-to-three hour diagnostic evaluation that typically takes place with an advanced- degree-candidate assessment trainee. Please keep in mind that the purpose of this evaluation is not to provide therapy; rather, it is to obtain a comprehensive picture of your problems, provide a preliminary diagnosis, and ascertain what treatment program can be of benefit to you. If our evaluation indicates that cognitive therapy will be an appropriate treatment for you, we will then assign a therapist to begin meeting with you for sessions. However, if the results of our evaluation suggest that outpatient cognitive therapy may not be the treatment of choice for you at this time, we will then refer you to a more appropriate treatment setting, and we will forward the results of our evaluation (with your permission).

Research has indicated that a full course of treatment yields the most positive results. Cognitive therapy is designed to be a short-term treatment (usually 12 to 20 sessions); however, depending on the nature and severity of your problems, the desirable length of treatment may be longer than this. It is important to keep in mind that dropping out of therapy before a full course has been completed has been shown to reduce the benefits of cognitive therapy.

If in the future you need to cancel a therapy session, please notify your therapist prior to the session, so you can reschedule a session promptly. The Center's policy is to require a minimum of 24 hours notice for cancellation (in regards to the evaluation as well as therapy sessions). If you call us on the day of the appointment to cancel or simply fail to arrive, we will have to charge a standard missed session fee of \$81.00. Please make every effort to speak to your therapist regarding any appointment cancellation before the 24 hour deadline. [Note: If you arrive late for a scheduled session, your therapist may still be available to see you, but only for the remainder of the time that has been allotted for your visit. However, you will be billed for the entire time for which the appointment was scheduled.]

Enclosed in this packet you will find several forms. Please complete these at home and bring them with you on the day of your evaluation. This will facilitate the evaluation process. At the time of your evaluation, please feel free to ask any questions you may have regarding cognitive therapy in general or the Center for Cognitive Therapy in particular. Thank you in advance for your cooperation.

Sincerely,

Cory Newman, Ph.D., ABPP  
Director



**UNIVERSITY OF  
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**Department of Psychiatry  
Center for Cognitive Therapy**

**CENTER POLICIES ON PATIENT FEES**

The Center for Cognitive Therapy is a non-profit organization which is part of the Department of Psychiatry in the University of Pennsylvania Health System. The purpose of this statement is to explain our fee structure and suggest ways to make payments more easily.

We require patients to pay their fee or co-pay each time they have a session. Please plan to arrive ten minutes before each session in order to check in with the administrative assistant (Tina Inforzato), pay your bill for that session (via cash, personal check, Visa, or Mastercard), and receive a receipt, as well as complete the appropriate session forms (such as the Beck mood inventories).

If you plan to seek reimbursement from your insurance company, the yellow receipt which you will be given contains all the information and codes needed by your insurance company. You should attach this to any insurance form which your company may require you to submit.

Mental health benefits vary greatly with each insurance company (whether in-network or out-of-network). We suggest that you contact your insurance company to determine your benefits. Things to be determined are: deductibles, percentage of the charge you will be reimbursed, number of visits allowed per year, and if services need to be precertified. Most insurance companies limit the number of mental health visits you may have each year. It is your responsibility to know your benefits and to keep track of sessions used. We will be happy to let you know at any time how many visits you have had with us, but we cannot determine when you have exceeded you limit since the total may include visits you may have had with providers not in our Center.

If your personal information or insurance coverage changes at any point during your treatment here, it is your responsibility to inform our staff immediately of the change. You may also contact the **UPHS Central Registration office (215)-615-2240**, in order to update your patient account. Failure to do so may result in loss of covered benefits here and increases in your financial responsibility.

If you must miss an appointment, please give us at least 24 hours notice. The clinician’s time is valuable and, if we have 24 hours notice, we can reschedule other clinical activities for him or her and we will not have to charge you for the missed session. For a missed psychotherapy session the late cancellation/no-show fee is **\$81.00**. The Center must charge for phone sessions which last beyond 15 minutes. Insurance benefits typically do not cover phone sessions or no-show fees.

In all instances, please do not hesitate to ask your therapist if you have any questions about our policy.

I have read and I understand all of the information contained above.

\_\_\_\_\_  
Patient’s Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date



**UNIVERSITY OF  
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**Department of Psychiatry  
Center for Cognitive Therapy**

**Informed Consent to Treatment at the Center for Cognitive Therapy**

Welcome to the Center for Cognitive Therapy at the University of Pennsylvania. This document contains important information about our services and policies. It will be a permanent part of your patient record. By signing it, you give your consent to treatment. If you have any questions about this form or other documents, please ask.

Any type of therapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, therapy often leads to better relationships, solutions to problems, and reductions in distress. The course of therapy differs for each individual. Cognitive therapy calls for active effort on your part, including your participation in the therapy sessions themselves, as well as the therapy homework assignments you will be asked to do.

To obtain treatment at the Center for Cognitive Therapy, you will undergo an evaluation conducted by a licensed clinician or by a trainee supervised by a licensed clinician. If we believe our services would be helpful for you in meeting your objectives, you will be offered therapy with a psychologist, clinical social worker, or supervised trainee (at a lower fee). Typically, therapy sessions are once a week for 45 to 50 minutes. The number of sessions varies according to the type of problems you have. You have the right to ask questions regarding your treatment, and your therapist will attempt to answer them to your satisfaction. If you withdraw from treatment, you have the right to a referral to another practitioner.

Most insurance companies require you to authorize your therapist to provide a clinical diagnosis; some require treatment plans or summaries. You can call your insurance company to find out how this information is stored or used. Your insurance company may limit the number of sessions it will cover.

All papers and documents concerning your treatment will be kept confidential. No information concerning your treatment will be released without your written consent, except as required by law or in a situation deemed potentially life threatening. By state law, licensed providers are mandated to report information that professional judgment determines constitutes a threat of serious harm to self or others, or indicates child abuse or neglect. Under these specific circumstances, information about you can be released without your written approval. However, your therapist will make every effort to keep you actively informed about such developments.

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Patient's name (printed)

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Signature of patient or legal guardian

Date signed

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Signature of witness (CCT staff member)

Date signed

Development date: 9/05



**UNIVERSITY OF  
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**A PATIENT’S BILL OF RIGHTS**

1. A patient has the right to receive treatment at the Center for Cognitive Therapy in an atmosphere of dignity and to be shown respect by all personnel.
2. A patient has the right to know and be involved in the formulation of individualized treatment plans, and the goals to be obtained through this treatment.
3. A patient has the right to know what risks, if any, are involved in treatment, and whether or not the treatment will include any new or experimental techniques (or medications if the patient is concurrently being seen by a psychiatrist or psychiatric Resident in the University of Pennsylvania Health System).
4. A patient has the right to refuse treatment.
5. A patient has the right to request an alternate treatment plan or type of therapy being provided.
6. A patient has the right to know that information and records regarding his or her treatment will be obtained and stored with the utmost confidentiality in accordance with the rules and regulations governing same.
7. A patient has the right to know the cost of treatment as well as any amount that may be billed through a third party.
8. A patient has the right to make grievances known via the following procedure: first, through the patient’s therapist; second, through the Director of the Center for Cognitive Therapy (Cory F. Newman, Ph.D., 215-898-3466); third through the Director of Clinical Services, Outpatient Psychiatry (Charles Dackis, M.D., 215-222-3200, x193).
9. A patient has the right to receive emergency service through the Emergency Room of the University of Pennsylvania Medical Center at any time, day or night, by calling the Emergency Room (215-662-2121).
10. A patient has the right to have any questions regarding treatment or policy to be answered promptly and appropriately by his or her therapist.

I acknowledge that I have read, and understand my rights as a patient here at the Center for Cognitive Therapy.

_____	_____	_____
Patient Signature	Date	
_____	_____	_____
Witness Signature	Date	

### PERSONAL DATA

First Name: _____	Middle Name: _____
Last Name: _____	Date: _____
Gender: <input type="radio"/> Male <input type="radio"/> Female	Birth Date: _____
Age: _____	
State/Country of Birth: _____	
Ethnicity (optional): <input type="radio"/> Native American <input type="radio"/> Asian <input type="radio"/> Black <input type="radio"/> Hispanic <input type="radio"/> White <input type="radio"/> Other	

<b>Home Address:</b>
Street: _____
City: _____
State: _____
Zip Code: _____
<b>Phone Number:</b>
Home: _____
Work: _____
Cell: _____
<b>May we call you at?:</b>
Home <input type="radio"/> Yes <input type="radio"/> No
Work <input type="radio"/> Yes <input type="radio"/> No
Cell <input type="radio"/> Yes <input type="radio"/> No
May we leave a message for you?: <input type="radio"/> Yes <input type="radio"/> No
May we leave a detailed message for you?: <input type="radio"/> Yes <input type="radio"/> No

<b>Employment Status:</b>
Full-time employed <input type="radio"/>
Part-time employed <input type="radio"/>
Unemployed seeking work <input type="radio"/>
Unemployed/other <input type="radio"/>
Full-time homemaker <input type="radio"/>
Retired <input type="radio"/>
Disabled <input type="radio"/>
Full-time student <input type="radio"/>
<b>Occupation:</b>
Self: _____
Place of Employment: _____
_____
Spouse/Partner: _____
Place of Employment: _____
_____

<b>Emergency Contact Person:</b>	<b>Home Address of Emergency Contact</b>
_____	_____
	Street
_____	_____
Phone Number	City, State and Zip

**PERSONAL DATA**  
(Side 2)

<b>Second Person to Contact:</b>	<b>Home Address of Second Person to Contact:</b>
_____	_____
_____	Street
_____	_____
Phone Number	City, State and Zip

**Education:**

- (1) 6<sup>th</sup> Grade
- (2) 7<sup>th</sup> to 11<sup>th</sup> Grade
- (3) High School Diploma
- (4) Some College
- (5) College Degree
- (6) Advanced Graduate or Professional School

**Your Marital Status:**

- Married
- Living as Married
- Widowed
- Divorced
- Separated
- Never Married

**Number of Children or Dependents:** \_\_\_\_\_

Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Living with you?  Yes  No

\_\_\_\_\_

Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Living with you?  Yes  No

\_\_\_\_\_

Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Living with you?  Yes  No

\_\_\_\_\_

Full Name: \_\_\_\_\_

Age: \_\_\_\_\_ Living with you?  Yes  No

\_\_\_\_\_

Others? \_\_\_\_\_

### MEDICAL HISTORY

First Name: _____	Last name: _____
Date: _____	

1. Who is your primary care physician or the physician who sees you most often (please include doctor's office phone number)? \_\_\_\_\_
2. When was the last time you had a physical check up? \_\_\_\_\_
3. Have you been treated by a physician or hospitalized in the last year?  Yes  No  
If yes please specify: \_\_\_\_\_
4. Has there been any change in your general health in the past year?  Yes  No  
If yes please specify: \_\_\_\_\_
5. Are you taking any non-psychiatric medication or over the counter drugs at the present time?  Yes  No  
If yes please list:

Medication	Dosage	Frequency	Name of Provider
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- 1.
- 2.
- 3.
- 4.
- 5.
6. Have you ever been told you had a thyroid problem?  Yes  No
7. Have you ever been told you had diabetes or hypoglycemia?  Yes  No
8. Do you get short of breath during mild exertion or when you lie down?  Yes  No
9. Do have a history of: (fill in circle for all that apply)
 

<input type="radio"/> Stroke	<input type="radio"/> Anemia	<input type="radio"/> Rheumatic Fever	<input type="radio"/> Asthma or COPD
<input type="radio"/> High or Low Blood Pressure	<input type="radio"/> Heart Pain (angina)	<input type="radio"/> Heart Murmur	<input type="radio"/> Heart Attack
<input type="radio"/> Heart Surgery	<input type="radio"/> Tuberculosis	<input type="radio"/> Ulcers	<input type="radio"/> Cancer
<input type="radio"/> Difficult pregnancy, labor, or delivery	<input type="radio"/> Premature termination of pregnancy (miscarriage or abortion)		
10. Are you pregnant or think you may be pregnant?  Yes  No  Not applicable \_\_\_\_\_
11. Have you ever had fits, seizures, convulsions, or epilepsy?  Yes  No
12. Do you have a prosthetic heart valve?  Yes  No
13. Do you have any other current medical conditions?  Yes  No  
If yes please specify: \_\_\_\_\_
14. Do you have any medication or food allergies?  Yes  No  
If yes please specify: \_\_\_\_\_

### PSYCHIATRIC HISTORY

First Name: _____	Last name: _____
Date: _____	

Have you ever been hospitalized for any emotional or psychiatric reason?  Yes  No

If yes, how many times have you been hospitalized? \_\_\_\_\_

	<u>Dates</u>	<u>Name of Hospital</u>	<u>Reason for Hospitalizations</u>	<u>Was it helpful?</u>
1.				
2.				
3.				

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Have you ever received psychiatric or psychological treatment before?  Yes  No

If yes, please complete:

	<u>Dates</u>	<u>Name of Clinician</u>	<u>Reason for Treatment</u>	<u>Was it helpful?</u>
1.				
2.				
3.				
4.				

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Are you taking any medication for psychiatric reasons?  Yes  No If yes, please complete:

	<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Name of prescriber</u>
1.				
2.				
3.				
4.				
5.				

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Have you ever made a suicide attempt?  Yes  No If yes, how many times have you attempted suicide? \_\_\_\_\_

	<u>Approximate date</u>	<u>What did you do to hurt your self?</u>	<u>Were you hospitalized?</u>
1.			
2.			

Others:

Have you ever experienced emotional or verbal abuse as a child?

Yes  No  Unsure

Have you ever experienced sexual abuse as a child?

Yes  No  Unsure

Have you ever experienced non-sexual physical abuse as a child?

Yes  No  Unsure

Have you ever experienced being raped (including acquaintance rape and marital rape)?

Yes  No  Unsure

Have you ever experienced emotional or verbal abuse as an adult?

Yes  No  Unsure

Have you ever experienced non-sexual physical abuse as an adult?

Yes  No  Unsure

Have you ever been concerned about your sexual behavior in terms of unusual practices, addiction, high-risk, identity confusion, or other matters?

Yes  No  Unsure

Has anyone in your family ever made a suicide attempt?

Yes  No  Unsure

If so, how is this person related to you? \_\_\_\_\_

Has anyone in your family died from suicide?

Yes  No  Unsure

If so, how is this person related to you? \_\_\_\_\_

Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse, or other addictions?

Yes  No  Unsure

If so, how are these persons related to you, and what is a summary of their problems?

### ALCOHOL AND DRUG USE HISTORY

First Name: _____	Last name: _____
Date: _____	

1. When did you last drink? \_\_\_\_\_
2. Has alcohol ever caused problems for you?  Yes  No
3. Has anyone ever told you that alcohol has caused a problem for you or complained about your drinking?  Yes  No
4. Has your use of alcohol ever caused a relationship problem with anyone?  Yes  No
5. Has your use of alcohol ever caused any problem at work or performing other responsibilities?  Yes  No
6. Has your use of alcohol ever caused any legal problems such as being arrested or being stopped for DUI?  Yes  No
7. Have you ever gotten "hooked" on a prescribed medication or taken a lot more of it than you were supposed to?  Yes  No  
If yes, please list those medications: \_\_\_\_\_
8. Have you ever been hospitalized because of a drug or alcohol problem?  Yes  No  
If yes, when and where were you hospitalized? \_\_\_\_\_
9. Have you ever been to a detoxification program?  Yes  No  
If yes, when and where did you receive such treatment? \_\_\_\_\_
10. Have you ever been to a drug or alcohol rehabilitation program?  Yes  No  
If yes, when and where did you receive such treatment? \_\_\_\_\_
11. Have you ever attended a 12 step meeting such as AA, NA, Al-Anon, Al-Ateen, ACOA?  Yes  No
12. Have you ever used any street drugs such as cocaine, marijuana, speed, LSD?  Yes  No  
If yes, please list all street drugs below: \_\_\_\_\_
13. Has anyone ever told you that drugs have caused a problem for you or complained about your drug use?  Yes  No
14. Has your use of drugs ever caused a relationship problem with anyone?  Yes  No
15. Has your use of drugs ever caused any problem at work or performing other responsibilities?  Yes  No
16. Have drugs ever caused any physical problems such as headaches, shakiness, stomach aches, seizures, or liver damage?  Yes  No
17. What is the longest period you have been drug free?(If applicable) \_\_\_\_\_
18. When was the last time you used any drugs? \_\_\_\_\_
19. Has your use of drugs ever cause any psychological problems such as feeling depressed?  Yes  No
20. Has your use of drugs ever caused any legal problems such as being arrested or being stopped for DUI?  Yes  No

# SCID-II QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**INSTRUCTIONS:** These questions are about the kind of person you generally are; that is, how you usually have felt or behaved over the past several years. Fill in “Yes” or “No.” Answer all the questions. If a question is unclear, pick the answer that best describes the kind of person that you are.

1. Have you avoided jobs or assignments that involved having to deal with a lot of other people?  Yes  No
2. Do you avoid getting involved with people unless you are certain they will like you?  Yes  No
3. Do you find it hard to be “open” even with people you are close to?  Yes  No
4. Do you often worry about being criticized or rejected in social situations?  Yes  No
5. Are you usually quiet when you meet people?  Yes  No
6. Do you believe that you are not as good, as smart, or as attractive as most other people?  Yes  No
7. Are you afraid to try new things?  Yes  No
8. Do you need a lot of advice or reassurance from others before you can make everyday decisions – such as what to wear or what in order in a restaurant?  Yes  No
9. Do you depend on other people to handle important areas in your life such as finances, child care, living arrangements?  Yes  No
10. Do you find it hard to disagree with people even when you think they are wrong?  Yes  No
11. Do you find it hard to start work on tasks when there is no one to help you?  Yes  No
12. Have you often volunteered to do things that are unpleasant?  Yes  No
13. Do you usually feel uncomfortable when you are by yourself?  Yes  No
14. When a close relationship ends, do you quickly need to find someone else you can rely on?  Yes  No
15. Do you worry a lot about being left alone to take care of yourself?  Yes  No
16. Are you the kind of person who focuses on details, order, and organization, or likes to make lists and schedules?  Yes  No

17. Do you have trouble finishing jobs because you spend so much time trying to get things exactly right?  Yes  No
18. Do you or other people feel that you are so devoted to work (school) that you have no time left for anyone else or for just having fun?  Yes  No
19. Do you have very high standards about what is right and what is wrong?  Yes  No
20. Do you have trouble throwing things out because they might come in handy some day?  Yes  No
21. Is it hard for you to let other people help out if they don't agree to do things exactly the way you want?  Yes  No
22. Is it hard for you to spend money on yourself and other people even when you have enough?  Yes  No
23. Are you often so sure you are right that it doesn't matter what other people say?  Yes  No
24. Have other people told you that you are stubborn or rigid?  Yes  No
25. When someone asks you to do something that you don't want to do, do you say "yes" but then work slowly or do a bad job?  Yes  No
26. Often, if you don't want to do something you just "forget" to do it?  Yes  No
27. Do you often feel that other people don't understand you, or don't appreciate how much you do?  Yes  No
28. Are you often gloomy and likely to get into arguments?  Yes  No
29. Have you often found that most of your bosses, teachers, supervisors, doctors, and others who are supposed to know what they are doing really don't?  Yes  No
30. Do you often think that it's not fair that other people have more than you do?  Yes  No
31. Do you often complain that only bad things happen to you?  Yes  No
32. Do you often go back and forth between telling someone off and then trying to make up by doing whatever they want?  Yes  No
33. Do you usually feel unhappy or like life is no fun?  Yes  No
34. Do you believe that you are basically an inadequate person and often feel not good about yourself?  Yes  No
35. Do you often put yourself down?  Yes  No

36. Are you a worrier?  Yes  No
37. Do you often judge others harshly and easily find fault with them?  Yes  No
38. Do you think that most people are basically no good?  Yes  No
39. Do you almost always expect the worst?  Yes  No
40. Do you often feel guilty about things you have or haven't done?  Yes  No
41. Do you often have to keep an eye out to stop people from using you or hurting you?  Yes  No
42. Do you spend a lot of time wondering if you can trust your friends or the people you work with?  Yes  No
43. Do you find that it is best not to let other people know too much about you?  Yes  No
44. Do you often pick up hidden meanings in what people say or do?  Yes  No
45. Are you the kind of person who holds grudges or takes a long time to forgive people who have insulted or slighted you?  Yes  No
46. Are there many people that you can't forgive because they did or said something to you a long time ago?  Yes  No
47. Do you often get angry or lash out when someone criticizes or insults you in some way?  Yes  No
48. Have you often suspected that your spouse or partner has been unfaithful?  Yes  No
49. When you are out in public and see people talking, do you often feel that they are talking about you?  Yes  No
50. Do you often get the feeling that things that appear to be unrelated are really meant to give you a special meaning?  Yes  No
51. Do you often detect hidden messages in seemingly unrelated events?  Yes  No
52. Have you ever felt that you could make things happen just by making a wish or thinking about them?  Yes  No
53. Have you had personal experiences with the supernatural?  Yes  No
54. Do you believe that you have a "sixth sense" that allows you to know and predict things that others can't?  Yes  No

55. Do you often think that objects or shadows are really people or animals or that noises are actually people's voices?  Yes  No
56. Have you had the sense that some person or force is around you, even though you cannot see anyone?  Yes  No
57. Do you often see auras or energy fields around people?  Yes  No
58. Are there very few people that you are really close to outside of your immediate family?  Yes  No
59. Do you often feel nervous when you are around other people?  Yes  No
60. Do you NOT feel close relationships with other people like family or friends?  Yes  No
61. Would you rather do things alone than with other people?  Yes  No
62. Could you be content without being sexually involved with another person?  Yes  No
63. Are there really very few things that give you a lot of pleasure?  Yes  No
64. Does it not matter to you what people think of you?  Yes  No
65. Do you find that nothing makes you very happy or very sad?  Yes  No
66. Do you like to be the center of attention?  Yes  No
67. Do you flirt a lot?  Yes  No
68. Do you often dress in a sexy way, even when you are going to work or doing errands?  Yes  No
69. Do you try to draw attention to yourself by the way you look or the way you dress?  Yes  No
70. Do you often make a point of being dramatic or colorful?  Yes  No
71. Do you find that your own opinions and feelings about things are not very strong so that you go along with other people's opinions?  Yes  No
72. Do you become very close with nearly everyone you meet?  Yes  No
73. Do most people fail to appreciate your very special talents or accomplishments?  Yes  No
74. Have people told you that you have too high an opinion of yourself?  Yes  No
75. Do you think a lot about the power, fame, or recognition that will be yours someday?  Yes  No

76. Do you think a lot about the perfect romance that will be yours someday?  Yes  No
77. When you have a problem, do you almost always insist on seeing the top person?  Yes  No
78. Do you feel its worth spending time only with people who are special or important?  Yes  No
79. Is it very important to you that people pay attention to you or admire you in some way?  Yes  No
80. Do you think that it's not necessary to follow certain rules or social conventions when they get in your way?  Yes  No
81. Do you often feel that there are reasons why other people should give you especially good treatment?  Yes  No
82. Do you often find it necessary to step on a few toes to get what you want?  Yes  No
83. Do you often have to put your needs above other people's?  Yes  No
84. Do you often expect other people to do what you ask without question because of who you are?  Yes  No
85. Do you often feel that it's not important to deal with other people's concerns or feelings?  Yes  No
86. Does it burn you up when other people do well?  Yes  No
87. Do you feel that others are often envious of you?  Yes  No
88. Do you find that very few people are worth your time and attention?  Yes  No
89. Have you often become frantic when you thought that someone you really care about was going to leave you?  Yes  No
90. Do your relationships with other people you really care about have lots of ups and downs?  Yes  No
91. Have you abruptly changed your sense of who you are and where you are headed?  Yes  No
92. Does your sense of who you are often change dramatically?  Yes  No
93. Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on?  Yes  No
94. Have you often done things impulsively?  Yes  No

95. Have you tried to hurt or kill yourself or threatened to do so?  Yes  No
96. Have you ever cut, burned, or scratched yourself on purpose?  Yes  No
97. Are you a “moody” person?  Yes  No
98. Do you often feel empty inside?  Yes  No
99. Do you often have temper outbursts or get so angry that you lose control?  Yes  No
100. Do you hit people or throw things when you get angry?  Yes  No
101. Do even little things get you very angry?  Yes  No
102. Do you get suspicious of other people or feel especially spaced out when you are under a lot of stress?  Yes  No

THE FOLLOWING QUESTIONS ARE ABOUT THINGS THAT YOU MAY HAVE DONE BEFORE YOU WERE FIFTEEN

103. ...did you bully or threaten other kids?  Yes  No
104. ...did you start fights?  Yes  No
105. ...did you use a weapon in a fight, like a bat, brick, broken bottle, a knife or gun?  Yes  No
106. ...did you ever deliberately try to cause someone physical pain and suffering?  Yes  No
107. ...did you sometimes hurt animals on purpose?  Yes  No
108. ...did you ever forcibly take something from someone by threatening, robbing, or mugging him or her?  Yes  No
109. ...did you ever force someone to have sex with you?  Yes  No
110. ...did you set fires?  Yes  No
111. ...did you deliberately damage things that weren't yours?  Yes  No
112. ...did you ever break into a house, other building, or car?  Yes  No
113. ...did you lie a lot or con other people?  Yes  No
114. ...did you ever steal or shoplift things?  Yes  No
115. ...did you run away from home and stay away overnight?  Yes  No

## BEFORE YOU WERE 13

116. ...would you often stay out very late, long after the time you were supposed to be home?  Yes  No

117. ...did you often skip school?  Yes  No

## CURRENT LIFE SITUATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### I. Current Problems and Daily Routine

A. What are the main problems that are causing you to seek treatment at this time:

B. Circle a number indicating the severity of your problems.

1	2	3	4	5	6	7	8	9	10
Mildly Upsetting		Moderately Upsetting		Severe		Extremely Severe			Incapacitating

C. When did your problems begin?

D. Please briefly describe what you do on a typical weekday, starting with the time you wake up in the morning and ending with the time you go to sleep at night.

1. Did this pattern change when your present difficulties began? Yes \_\_\_\_\_ No \_\_\_\_\_

2. If yes, in what way?

E. Please briefly describe what you do on your weekends or days off.

1. Did this pattern change when your present difficulties began? Yes \_\_\_\_\_ No \_\_\_\_\_

2. If yes, in what way?

## CURRENT LIFE SITUATION

### II. Current Social Life

A. Describe how you are getting along with people other than your family or those you live with (e.g., friends, acquaintances, neighbors, co-workers) and how people generally seem to feel about you. If you are having problems relating to other people, please describe those problems.

B. Have your relationships with friends, acquaintances, neighbors, or co-workers changed as a result of your current difficulties? Yes \_\_\_\_\_ No \_\_\_\_\_

1. If yes, briefly describe the ways in which they have changed.

C. How difficult is it for you to make friends these days? (circle number)

1	2	3	4	5	6	7	8	9	10
Very Difficult		Somewhat Difficult		About Average		Somewhat Easy		Very Easy	

D. How difficult is it for you to *keep* friends these days? (circle number)

1	2	3	4	5	6	7	8	9	10
Very Difficult		Somewhat Difficult		About Average		Somewhat Easy		Very Easy	

E. About how many close friends do you have (people you can confide in)? \_\_\_\_\_

1. How often do you talk to them?

2. How often do you see them?

F. Rate the degree to which you generally feel relaxed and comfortable in social situations. (circle a number)

1	2	3	4	5	6	7	8	9	10
Very Tense and Uncomfortable		Somewhat Tense and Uncomfortable		Neutral		Somewhat Relaxed and Comfortable		Very Relaxed and Comfortable	

## CURRENT LIFE SITUATION

### III. Current Work (and/or School) Life

A. Briefly describe your attitude and behavior at work or school. Describe any problems you are having carrying out your responsibilities or dealing with problems.

1. Did your attitude or behavior change when your present difficulties began?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. If yes, in what way?

B. What do you like about your current line of work, or schooling?

C. What do you dislike about your current line of work, or schooling?

### IV. Intimate Relationships

A. How comfortable are you now with the idea of being trusting, open, and close (vulnerable) in a love relationship? (Please answer even if you are not currently in such a relationship – circle a number)

1	2	3	4	5	6	7	8	9	10
Extremely <i>Uncomfortable</i>	Moderately <i>Uncomfortable</i>	Neutral <i>Fairly Self-</i>	Fairly Self- <i>Protective but</i>	Neutral <i>Willing to be</i>	Fairly Self- <i>Willing to be</i>	Moderately <i>Comfortable</i>	Moderately <i>With Closeness;</i>	Extremely <i>Comfortable</i>	Extremely <i>Comfortable</i>
With Closeness; <i>Very Self-</i>	With Closeness; <i>Pretty Self-</i>	Protective but <i>Protective</i>	Willing to be <i>Protective</i>	Willing to be <i>Vulnerable at Times</i>	Willing to be <i>Vulnerable</i>	With Closeness; <i>Pretty Willing to be</i>	With Closeness; <i>Pretty Willing to be</i>	With Closeness; <i>Very Willing to</i>	With Closeness; <i>Very Willing to</i>
Very Self- <i>Protective</i>	Pretty Self- <i>Protective</i>	Protective <i>Protective</i>	Protective but <i>Protective</i>	Willing to be <i>Vulnerable at Times</i>	Willing to be <i>Vulnerable</i>	Pretty Willing to be <i>Vulnerable</i>	Pretty Willing to be <i>Vulnerable</i>	Very Willing to <i>be Vulnerable</i>	Very Willing to <i>be Vulnerable</i>

B. IF NOT MARRIED OR COHABITATING: Are you currently dating anyone? Yes No

1. If yes, are you experiencing significant difficulties in this/these dating relationship(s)?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. If yes, please describe.

## CURRENT LIFE SITUATION

3. If you are not currently dating anyone, how satisfied are you with this situation?

Completely Dissatisfied \_\_\_\_\_ Mostly Dissatisfied \_\_\_\_\_  
 Somewhat Dissatisfied \_\_\_\_\_ Neutral \_\_\_\_\_  
 Evenly Mixed (Conflicted) Feelings \_\_\_\_\_ Somewhat Satisfied \_\_\_\_\_  
 Mostly Satisfied \_\_\_\_\_ Completely Satisfied \_\_\_\_\_

- C. IF MARRIED OR COHABITATING: Rate your overall level of satisfaction with the marital/committed relationship. (circle a number)

1	2	3	4	5	6	7	8	9	10
Very Dissatisfied		Moderately Dissatisfied		Neutral		Moderately Satisfied		Very Satisfied	

1. Indicate which, if any, are the positive aspects of the relationship for you.

2. Indicate which, if any, are the negative aspects of the relationship for you.

- D. On a scale from one to ten, indicate how critical you think your spouse/partner is of you? (circle a number)

1	2	3	4	5	6	7	8	9	10
Not at All Critical		Mildly Critical		Moderately Critical		Pretty Critical		Very Critical	

- E. On a scale from one to ten, indicate how satisfied you are with the quality of your sexual relations with your partner. (circle a number)

1	2	3	4	5	6	7	8	9	10
Very Dissatisfied		Moderately Dissatisfied		Neutral		Moderately Satisfied		Very Satisfied	

- F. List any sexual problems that might be related to your reason for seeking treatment.

### CURRENT LIFE SITUATION

G. IF COHABITATING: Do you plan to formalize your commitment?

Yes \_\_\_ No \_\_\_ Unsure\_\_\_

If "No" or "Unsure" what are the obstacles to a long-term formal commitment?

V. Children and Family Relationships

A. List below each child with whom you have a parental relationship whether as a biological parent, stepparent, or other relationship.

Name of Child	Age	Relationship (e.g., daughter, son, stepdaughter, stepson, etc.)	If the child does not live with you full- time, explain living arrangements.

B. Do any of your children present special problems to you and/or your spouse/partner?  
Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe:

C. How would you describe your present relationship with your family of origin?

D. Indicate which, if any, of these relationships is currently a significant source of support or distress for you. If a relationship is problematic, describe briefly what the problem(s) seems to be.

**LIFE HISTORY INVENTORY**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## I. Family of Origin

A. Father: Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health: \_\_\_\_\_

If deceased, give age at time of death: \_\_\_\_\_ How old were you at the time? \_\_\_\_\_

Cause of death: \_\_\_\_\_

B. Mother: Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health: \_\_\_\_\_

If deceased, give age at time of death: \_\_\_\_\_ How old were you at the time? \_\_\_\_\_

Cause of death: \_\_\_\_\_

C. Siblings: Age(s) of brother(s): \_\_\_\_\_ Age(s) of sister(s): \_\_\_\_\_

Where were you in birth order? \_\_\_\_\_

Any significant details about siblings: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## D. Disruptions in childhood upbringing:

1. Did you experience any significant moves as a child? Yes \_\_\_\_\_ No \_\_\_\_\_

a. If yes, how old were you? \_\_\_\_\_

b. Did you have significant emotional or behavioral difficulties associated with the move(s)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe your difficulties:

**LIFE HISTORY INVENTORY**

2. Were you ever separated from one or both parents for a significant period of time during your childhood? Yes \_\_\_\_\_ No \_\_\_\_\_
- a. If yes, how old were you? \_\_\_\_\_
- b. Did you have any significant emotional or behavioral difficulties associated with the separation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what were the difficulties and what were the circumstances and reason for the separation?

3. If you were not raised by your parents, who raised you and between what years of age?

E. How would you characterize your father (or father substitute) when you were a child?

1. What was his attitude toward you as a child?
2. How much were you able to confide in your father as a child?
3. How did your father discipline you when you misbehaved?

## **LIFE HISTORY INVENTORY**

F. How would you characterize your mother (or mother substitute) when you were a child?

1. What was her attitude toward you as a child?
2. How much were you able to confide in your mother as a child?
3. How did your mother discipline you when you misbehaved?

G. Describe the atmosphere in the home in which you grew up.

1. How did your parents get along?
2. How did the children get along?
3. What were some of the important spoken or unspoken family rules?

**LIFE HISTORY INVENTORY**

4. How openly were affection and anger expressed?
5. How were problems handled?
6. What were your parents' attitudes about sex? How much was sex discussed in the home?
7. How involved were your parents in the social interests of the children? How comfortable did you feel having your friends over to the house?
- H. If you have a stepparent, how old were you when your biological parent(s) remarried? \_\_\_\_\_
- I. Was religion an important part of your upbringing? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, in what way was it important?
- J. Did you have any particular fears as a child? Yes \_\_\_\_\_ No \_\_\_\_\_
1. If yes, what were they?
2. Which of these, if any, do you still have?

## LIFE HISTORY INVENTORY

### II. School/Occupational History

A. How did you feel about school as you grew up?

1. Elementary:
2. High School:
3. College:
4. Post-graduate education:

B. How were your grades?

1. Elementary:
2. High school:
3. College:
4. Post-graduate education:

C. Growing up, were you ever in trouble with the police or school authorities?

Yes \_\_\_\_\_ No \_\_\_\_\_

1. If yes, how old were you at the time? \_\_\_\_\_
2. Describe specific incident(s):

D. Did you graduate from:

1. High school? Yes \_\_\_\_\_ No \_\_\_\_\_ Year \_\_\_\_\_
2. A vocational training program? Yes \_\_\_\_\_ No \_\_\_\_\_ Year \_\_\_\_\_
3. College? Yes \_\_\_\_\_ No \_\_\_\_\_ Year \_\_\_\_\_
4. Graduate/professional school? Yes \_\_\_\_\_ No \_\_\_\_\_ Year \_\_\_\_\_
5. Did you take any time off from school during your education? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, why?

## LIFE HISTORY INVENTORY

E. Describe the types of jobs you have held and the reasons for leaving past jobs.

DATES	JOB DESCRIPTION	EMPLOYER	REASON FOR ENDING

F. Have you made a career change? Yes\_\_\_\_\_ No\_\_\_\_\_

1. If yes, describe what led to your career change(s).

### III. Social History: Friendships

A. As a child (younger than age 13), how difficult was it for you to make friends?  
(circle a number)

1	2	3	4	5	6	7	8	9	10
Very Difficult	Somewhat Difficult		About Average			Somewhat Easy		Very Easy	

## LIFE HISTORY INVENTORY

B. As a child, how difficult was it for you to *keep* friends? (circle a number)

1	2	3	4	5	6	7	8	9	10
Very Difficult	Somewhat Difficult			About Average		Somewhat Easy		Very Easy	

C. About how many close friends did you have as a child? \_\_\_\_\_

D. As an adolescent, how difficult was it for you to make friends? (circle a number)

1	2	3	4	5	6	7	8	9	10
Very Difficult	Somewhat Difficult			About Average		Somewhat Easy		Very Easy	

E. As an adolescent, how difficult was it for you to *keep* friends? (circle a number)

1	2	3	4	5	6	7	8	9	10
Very Difficult	Somewhat Difficult			About Average		Somewhat Easy		Very Easy	

F. About how many close friends did you have as an adolescent? \_\_\_\_\_

### IV. Social History: Intimate Relationships

A. At what age did you start dating? \_\_\_\_\_

B. List the serious relationships from your past (if any) that you think have had the most impact on you. Do not include ongoing committed relationships.

First Name	His/Her age now	Year you became a couple	Year you moved in together (if applicable)	Year you married (if applicable)	Year you separated or broke up	Year you divorced (if applicable)

## LIFE HISTORY INVENTORY

C. Is there any common pattern that seems to take place in many of your romantic involvements?

D. IF MARRIED OR COHABITATING:

1. What year did you meet your spouse/partner?
2. What did you like about him/her?

3. How long did you know each other before getting married/living together?

E. How much would you describe yourself as attracted to the *opposite* sex?

1	2	3	4	5	6	7	8	9	10
Definitely Not		Mostly Not		Somewhat or Unsure		Mostly Yes		Definitely Yes	

F. How much would you describe yourself as attracted to the *same* sex?

1	2	3	4	5	6	7	8	9	10
Definitely Not		Mostly Not		Somewhat or Unsure		Mostly Yes		Definitely Yes	