Penn Medicine

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. (Alternatively, you may fill them out on your computer and return them via encrypted e-mail). It is very important that you fill them out in their entirety prior to your evaluation. We appreciate your time and effort in completing this lengthy and important questionnaire. If you have any questions, please feel free to contact 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 at 3535 Market Street, which is on the northeast corner of 36th and Market Street. If your appointment is on site, please use the elevator after signing in with Security in the lobby and go to the 3rd floor, where you will check in. After making payment for your appointment, please take the elevator to the 4th floor CCT waiting room (on the side of the floor opposite Suite 4100). The therapist who will be conducting your intake evaluation will come out to greet you soon.

Thank you.

The therapists and staff of the Center for Cognitive Therapy.

Penn Medicine

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-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-behavioral 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-behavioral 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-behavioral 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. You and your therapist will collaboratively decide on the length of your treatment, and this decision does not have to be made at the start. It is important to keep in mind that dropping out of therapy prematurely has been shown to reduce the benefits of cognitive-behavioral therapy.

If in the future you need to cancel a therapy session, please notify your therapist prior to the session, so you can reschedule the session at the first opportunity. 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 contact us on the day of the appointment to cancel or simply fail to arrive, you may be charged for the missed appointment. Please make every effort to speak to your therapist regarding any appointment cancellation prior to 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 (or return them via encrypted e-mail). This will facilitate the evaluation process. At the time of your evaluation, please feel free to ask any questions you may have regarding cognitive-behavioral therapy in general or the Center for Cognitive Therapy in particular. Thank you in advance for your cooperation.

Sincerely,

Cory F. Newman, Ph.D., ABPP
Director

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. If your session is on-site, please plan to arrive ten minutes before each session in order to check in with the administrative assistant on the 3rd floor, pay your bill for that session (via cash, personal check, Visa, MasterCard or Discover), and receive a receipt, as well as complete the appropriate session forms (such as the Beck mood inventories).

If you plan to seek out-of-network reimbursement from your insurance company, the 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 pre-certified. Some 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 your 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. Failure to do so may result in loss of covered benefits here and increased 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. The Center must charge for phone contacts that last beyond 10 minutes. Insurance benefits typically do not cover phone session or no-show fees.

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

Please sign below to indicate that you understand all of the information contained above.

Patient's Name	Signature of Patient	Date
Staff Member Name	Signature of Staff Member	Date

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 somewhat for each individual. Cognitive-behavioral 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 clinical trainee (at a lower fee). Typically, therapy sessions are once a week for 45 to 55 minutes, though the frequency of sessions may vary. The number of sessions also varies according to the type of problems you are addressing. 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 you 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.

Patient's Name	Signature of Patient or Legal Guardian	Date
Staff Member Name	Signature of Witness (CCT Staff Member)	Date

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Department of Psychiatry | Center for Cognitive Therapy

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 alternative 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, though the patient's therapist; or second through the Director of the Center for Cognitive Therapy, Cory F. Newman, Ph.D. at (215) 898-3466.

9. A patient has the right to seek emergency services through The Pennsylvania Hospital Crisis Response Center at (215) 829-5433.

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, or by the Director.

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

Patient's Name	Signature of Patient	Date
Staff Member Name	Signature of Witness (CCT Staff Member)	Date

PERSONAL DATA

First Name	Middle Name
Last Name	Date
Gender	Age
State of Birth (optional)	Country of Birth (optional)

Ethnicity (optional)

○ Native America ○ Asian ○ Black ○ Hispanic

○ White Other

Home Address:

Street:

City:

State:

ZIP Code:

Phone Number:

Home:

Work:

Cell:

May we call you at?

Home

○ Yes ○ No

Work

○ Yes ○ No

Cell

○ Yes ○ No

Employment Status ("other" if you are a full-time student and not also employed)

- ○ Full-time employed
- ○ Part-time employed
- ○ Unemployed seeking work
- ○ Unemployed / Other
- ○ Full-time homemaker
- ○ Retired
- ○ Disabled

Occupation (including "student")

Self

Place of Employment

Spouse / Partner (Optional)

Place of Employment (Optional)

Primary Emergency Contact Person	Primary Home Address of Emergency Contact
Contact Name	Street Address
Contact Phone Number	City, State and ZIP

Secondary Emergency Contact Person	Secondary Home Address of Emergency Contact
Contact Name	Street Address
Contact Phone Number	City, State and ZIP

Education

- ○ Up to 6th Grade
- ○ 7th to 12th Grade
- ○ High School Diploma
- ○ Trade School Diploma
- ○ Some College
- ○ College Degree
- ○ 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

Who is your primary care physician or the physician who sees you most often?	Doctor office phone number
When was the last time you had a physical checkup?	
Have you been treated by a physician or hospitalized in the last year?	○ Yes ○ No
Has there been any change in your general health in the past year?	○ Yes ○ No
Are you taking any non-psychiatric mediation or over the counter drugs at the present time? If so, please list.	○ Yes ○ No

Medications	Dosage	Frequency	Name of Provider

Have you ever been told you had a thyroid problem?	○ Yes ○ No
Have you ever been told you had diabetes or hypoglycemia?	○ Yes ○ No
Do you get short of breath during mild exertion or when you lie down?	○ Yes ○ No

Do you have a history of (select all that apply)? ☐ Stroke ☐ Anemia ☐ Rheumatic Fever ☐ Asthma or COPD ☐ High or Low Blood Pressure ☐ Heart Pain (Angina) ☐ Heart Murmur ☐ Heart Attack ☐ Heart Surgery ☐ Tuberculosis ☐ Ulcers ☐ Cancer ☐ Difficult pregnancy, labor or delivery ☐ Premature termination of pregnancy (miscarriage or abortion) [optional]	
Are you pregnant or think you may be pregnant? [optional]	○ Yes ○ No ○ Not Applicable
Have you ever had fits, seizures, convulsions or epilepsy?	○ Yes ○ No
Do you have a prosthetic heart valve?	○ Yes ○ No
Do you have any other medical conditions? If yes, please specify.	○ Yes ○ No
Do you have any medication or food allergies? If yes, please specify.	○ Yes ○ No

PSYCHIATRIC HISTORY

First Name	Last Name	Date

Have you ever been hospitalized for any emotional of psychiatric reason?	○ Yes	○ No	
Dates	Name of Hospital	Reason for Hospitalization	Was it helpful?
Dates	Name of Hospital	Reason for Hospitalization	Was it helpful?
Dates	Name of Hospital	Reason for Hospitalization	Was it helpful?

Have you ever received psychiatric or psychological treatment before?	○ Yes	○ No	
Dates	Name of Clinician	Reason for Treatment	Was it helpful?
Dates	Name of Clinician	Reason for Treatment	Was it helpful?
Dates	Name of Clinician	Reason for Treatment	Was it helpful?
Dates	Name of Clinician	Reason for Treatment	Was it helpful?

Are you taking any psychiatric medication (e.g. anti-depressants)?			◯ Yes ◯ No
Medication	Dosage	Frequency	Name of Prescriber
Medication	Dosage	Frequency	Name of Prescriber
Medication	Dosage	Frequency	Name of Prescriber
Medication	Dosage	Frequency	Name of Prescriber
Medication	Dosage	Frequency	Name of Prescriber

Have you ever made a suicide attempt? ◯ Yes ◯ No Approximate Date	How many times? What did you do to hurt yourself?	Were you hospitalized? ◯ Yes ◯ No
Approximate Date	What did you do to hurt yourself?	Were you hospitalized?
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, identify confusion or other matters?	○ Yes ○ No ○ Unsure
Has anyone in your family ever made a suicide attempt? If so, how is this person related to you?	○ Yes ○ No ○ Unsure
Has anyone in your family died from suicide? If so, how is this person related to you?	○ Yes ○ No ○ Unsure
Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse or other addictions? If so, how are these persons related to you and what is a summary of their problem?	○ Yes ○ No ○ Unsure

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 a 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? If yes, please list those medication(s).	Yes No
8.	Have you ever used any street drugs such as cocaine, marijuana, speed, LSD? If yes, please list all street drugs below.	Yes No
9.	When was the last time you used any drugs?	
10.	Have you ever been hospitalized because of a drug or alcohol problem? If yes, when and where were you hospitalized?	Yes No
11.	Have you ever been to a detoxification program? If yes, when and where did you receive such treatment?	Yes No
12.	Have you ever been to a drug or alcohol rehabilitation program? If yes, when and where did you receive such treatment?	Yes No
13.	Have you ever attended a 12-step meeting such as AA, NA, Al-Anon, Al-Ateen, ACOA?	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.	Has your use of drugs ever cause any psychological problems such as feeling depressed?	◯ Yes ◯ No

INSTRUCTIONS

These questions are about the kind of person you generally are; that is, how you have usually felt or behaved over the past several years. Select "Yes" if the question completely or most applies to you or "No" if the question does not generally apply to you. If you do not understand a question, leave it blank.

1.	Have you avoided jobs or tasks that involved having to deal with a lot of people?	○ Yes ○ No	PQ4
2.	Do you avoid making friends with people unless you are certain they will like you?	○ Yes ○ No	PQ5
3.	Do you find it hard to be "open" even with people you are close to?	○ Yes ○ No	PQ6
4.	Do you often worry about being criticized or rejected in social situations?	○ Yes ○ No	PQ7
5.	Are you usually quiet when you meet new people?	○ Yes ○ No	PQ8
6.	Do you believe that you're not as good, as smart, or as attractive as most other people?	○ Yes ○ No	PQ9
7.	Are you afraid to do things that might be challenging or to try anything new?	○ Yes ○ No	PQ10
8.	Is it hard for you to make everyday decisions, like what to wear of what to order in a restaurant, without advice and reassurance from others?	○ Yes ○ No	PQ11
9.	Do you depend on other people to handle important areas of your life, such as finances, child care or living arrangements?	○ Yes ○ No	PQ12
10.	Do you have trouble disagreeing with people even when you think they are wrong?	○ Yes ○ No	PQ13
11.	Do you find it hard to start projects or do things on your own?	○ Yes ○ No	PQ14
12.	Is it so important to you to be taken care of by others that you are willing to do unpleasant or unreasonable things for them?	○ Yes ○ No	PQ15
13.	Do you usually feel uncomfortable when you are by yourself?	○ Yes ○ No	PQ16
14.	When a close relationship ends, do you feel you immediately have to find someone else to take care of you?	○ Yes ○ No	PQ17
15.	Do you worry a lot about being left alone to take care of yourself?	○ Yes ○ No	PQ18
16.	Are you the kind of person who spends a lot of time focusing on details, order, or organization or making lists and schedules?	○ Yes ○ No	PQ19
17.	Do you have trouble finishing things because you spend so much time trying to get them exactly right?	○ Yes ○ No	PQ20
18.	Are you very devoted to your work or to being productive?	○ Yes ○ No	PQ21
19.	Do you have very high standards about what is right and what is wrong?	○ Yes ○ No	PQ22
20.	Do you have trouble throwing things out because they might come in handy someday?	○ Yes ○ No	PQ23
21.	Is it hard for you to work with other people or ask others to do things if they don't agree to do things exactly the way you want?	○ Yes ○ No	PQ24
22.	Is it hard for you to spend money on yourself and other people?	○ Yes ○ No	PQ25
23.	Once you've made plans, is it hard for you to make changes?	○ Yes ○ No	PQ26
24.	Have other people said that you are stubborn?	○ Yes ○ No	PQ27
25.	Do you often get the feeling that people are using you, hurting you or lying to you?	○ Yes ○ No	PQ28
26.	Are you a very private person who rarely confides in other people?	○ Yes ○ No	PQ29
27.	Do you find that it is best not to let other people know much about you because they will use it against you?	○ Yes ○ No	PQ30
28.	Do you often feel that people are threatening or insulting you by the things they say or do?	○ Yes ○ No	PQ31
29.	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	PQ32

30. Are there a lot of people you can't forgive because they did or said something to you a long time ago?	○ Yes ○ No	PQ33
31. Do you often get angry or lash out when someone criticizes or insult you in some way?	○ Yes ○ No	PQ34
32. Have you sometimes suspected that your spouse or partner has been unfaithful?	○ Yes ○ No	PQ35
33. When you are out in public and see people talking, do you often feel they are talking about you?	○ Yes ○ No	PQ36
34. When you are around people, do you often get the feeling that you are being watched or stared at?	○ Yes ○ No	PQ37
35. Do you often get the feeling that the words to a song or something in a movie or on TV has a special meaning for you in particular?	○ Yes ○ No	PQ38
36. Are you a superstitious person?	○ Yes ○ No	PQ39
37. Have you ever felt that you could make things happen just by making a wish or thinking about them?	○ Yes ○ No	PQ40
38. Have you had personal experience with the supernatural?	○ Yes ○ No	PQ41
39. Do you believe that you have a "sixth sense" that allows you to know and predict things?	○ Yes ○ No	PQ42
40. Do you often have the feeling that everything is unreal, that you are detached from your body or mind, or that you are an outside observer of you own thoughts or movements?	○ Yes ○ No	PQ43
41. Do you often see things that other people don't see?	○ Yes ○ No	PQ44
42. Do you often hear a voice softly speaking your name?	○ Yes ○ No	PQ45
43. Have you had the sense that some person or force is around you, even though you cannot see anyone?	○ Yes ○ No	PQ46
44. Are there very few people who you're really close to outside of your immediate family?	○ Yes ○ No	PQ47
45. Do you often feel nervous when you are around people you don't know very well?	○ Yes ○ No	PQ48
46. Is it NOT important to you to have friends or romantic relations or to be involved with your family?	○ Yes ○ No	PQ49
47. Would you almost always rather do things alone than with other people?	○ Yes ○ No	PQ50
48. Do you have little or no interest in having sexual experiences with another person?	○ Yes ○ No	PQ51
49. Are there really very few things that give you pleasure?	○ Yes ○ No	PQ52
50. Does it not matter to you what people think of you?	○ Yes ○ No	PQ53
51. Do you rarely have strong feelings, like being very angry or feeling joyful?	○ Yes ○ No	PQ54
52. Do you like being the center of attention?	○ Yes ○ No	PQ55
53. Do you tend to flirt a lot?	○ Yes ○ No	PQ56
54. Do you often find yourself "coming on" to people?	○ Yes ○ No	PQ57
55. Do you like to draw attention to yourself by the way you dress or look?	○ Yes ○ No	PQ58
56. Do you tend to be very dramatic in your actions and speech?	○ Yes ○ No	PQ59
57. Are you more emotional than most other people, for example sobbing when you hear a sad story?	○ Yes ○ No	PQ60
58. Do you often change your mind about things depending on the people you're with or what you have just read or seen on tv?	○ Yes ○ No	PQ61
59. Do you feel that you are good friends, even with people who provide a service, like your plumber, your car mechanic and your doctor?	○ Yes ○ No	PQ62
60. Are you more important, more talented or more successful than most other people?	○ Yes ○ No	PQ63
61. Have people told you that you have too high an opinion of yourself?	○ Yes ○ No	PQ64
62. Do you think a lot about the power, success or recognition that you expect to be yours someday?	○ Yes ○ No	PQ65

63. Do you think a lot about the perfect romance that will be yours someday?	○ Yes ○ No	PQ66
64. When you have a problem, do you almost always insist on seeing the top person?	○ Yes ○ No	PQ67
65. Do you try to spend time with people who are important or influential?	○ Yes ○ No	PQ68
66. Is it important to you that people pay attention to you or admire you in some way?	○ Yes ○ No	PQ69
67. Do you fell that you are the kind of person who deserves special treatment or that other people should automatically do what you want?	○ Yes ○ No	PQ70
68. Do you often have to put your needs about other people's?	○ Yes ○ No	PQ71
69. Have others complained that you take advantage of people?	○ Yes ○ No	PQ72
70. Do you generally feel that other people's needs or feelings are really not your problem?	○ Yes ○ No	PQ73
71. Do you often find other people's problems to be boring?	○ Yes ○ No	PQ74
72. Have people complained to you that you don't listen to them or care about their feelings?	○ Yes ○ No	PQ75
73. When you see someone who is successful, do you feel that you deserve it more than they do?	○ Yes ○ No	PQ76
74. Do you feel that others are often envious of you?	○ Yes ○ No	PQ77
75. Do you find that there are very few people who are worth your time and attention?	○ Yes ○ No	PQ78
76. Have other people complained that you act too "high and mighty" or arrogant?	○ Yes ○ No	PQ79
77. Have you become frantic when you thought that someone you really cared about was going to leave you?	○ Yes ○ No	PQ80
78. Do relationships with people you really care about have lots of extreme ups and downs?	○ Yes ○ No	PQ81
79. Does your sense of who you are often change dramatically?	○ Yes ○ No	PQ82
80. Are you different with different people or in different situations so that you sometime don't know who you really are?	○ Yes ○ No	PQ83
81. Have there been lots of sudden changes in your goals, career plans, religious beliefs and so on?	○ Yes ○ No	PQ84
82. Have there been lots of sudden changes in the kinds of friends you have or in your sexual identity?	○ Yes ○ No	PQ85
83. Have you often done things impulsively?	○ Yes ○ No	PQ86
84. Have you tried to hurt of kill yourself or threated to do so?	○ Yes ○ No	PQ87
85. Have you ever cut, burned or scratched yourself on purpose?	○ Yes ○ No	PQ88
86. Does your mood often change in a single day based on what's going on in your life?	○ Yes ○ No	PQ89
87. Do you often feel empty inside?	○ Yes ○ No	PQ90
88. Do you often have temper outbursts or get so angry that you lose control?	○ Yes ○ No	PQ91
89. Do you hit people or throw things when you get angry?	○ Yes ○ No	PQ92
90. Do even little things get you very angry?	○ Yes ○ No	PQ93
91. When you get very upset, do you get suspicious of other people or feel disconnected from your body or that things are unreal?	○ Yes ○ No	PQ94
92. Before you were 15, did you bully, threaten or scare other kids?	○ Yes ○ No	PQ95
93. Before you were 15, did you start fights?	○ Yes ○ No	PQ96
94. Before you were 15, did you hurt or threaten someone with a weapon, like a bat, brick, broken bottle, a knife or a gun?	○ Yes ○ No	PQ97
95. Before you were 15, did you do cruel things to someone that caused him or her physical pain of suffering?	○ Yes ○ No	PQ98

96. Before you were 15, did you hurt animals on purpose?	○ Yes ○ No	PQ99
97. Before you were 15, did you mug, rob or forcibly take something from someone by threatening him of her?	○ Yes ○ No	PQ100
98. Before you were 15, did you force someone to do something sexual?	○ Yes ○ No	PQ101
99. Before you were 15, did you set fires?	○ Yes ○ No	PQ102
100. Before you were 15, did you deliberately destroy things that weren't yours??	○ Yes ○ No	PQ103
101. Before you were 15, did you break into houses, other building or cars?	○ Yes ○ No	PQ104
102. Before you were 15, did you lie a lot or con other people to get something you wanted or to get out of doing something?	○ Yes ○ No	PQ105
103. Before you were 15, did you sometimes shoplift, steal something or forge someone's signature for money?	○ Yes ○ No	PQ106
104. Before you were 15, did you run away and stay away overnight?	○ Yes ○ No	PQ107
The following two questions apply to things you did before you were 13 years old.		
105. Before you were 13, did you often stay out very late, long after the time you were supposed to be home?	○ Yes ○ No	PQ108
106. Before you were 13, did you often skip school?	○ Yes ○ No	PQ109

CURRENT LIFE SITUATIONS

First Name	Last Name	Date

I. Current Problems and Daily Routine

What are the main problems that are causing you to seek treatment at this time?

Indicate a number representing the severity of your problem.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Mildly Upsetting | Moderately Upsetting | Severe | Extremely Severe | Incapacitating

When did your problems begin?

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.

Did this pattern change when your present difficulties began? ○ Yes ○ No

If yes, in what way?

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

Did this pattern change when your present difficulties began? ○ Yes ○ No

If yes, in what way?

II. Current Social Life

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.

Have your relationships with friends, acquaintances, neighbors or co-workers changed as a result of your current difficulties?

○ Yes ○ No

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

How difficult is it for you to make friends these days?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Difficult | Somewhat Difficult | About Average | Somewhat Easy | Very Easy

How difficult is it for you to keep friends these days?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Difficult | Somewhat Difficult | About Average | Somewhat Easy | Very Easy

About how many close friends do you have (people you can confide in)?

How often do you talk to them?

How often do you see them?

Rate the degree to which you generally feel relaxed and comfortable in social situations.

○ 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

III. Current Work (and / or School) Life

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

Did this pattern change when your present difficulties began? ○ Yes ○ No

If yes, in what way?

IV. Intimate Relationships

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 ins such a relationship)

Moderately Uncomfortable with Closeness; Pretty Self-Protective

Moderately comfortable with closeness; Pretty willing to be vulnerable

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Extremely Uncomfortable with Closeness; Very Self-Protective

Neutral, Fairly Self-Protective, but willing to be vulnerable at times

Extremely comfortable with closeness; Very willing to be vulnerable

If not married or cohabitating: Are you currently dating anyone? ○ Yes ○ No

If yes, are you experiencing significant difficulties in this / these dating relationships(s)? ○ Yes ○ No

If yes, please describe.

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
○ Completely Satisfied

If married or cohabitating: Rate you overall level of satisfaction with the marital / committed relationship.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Dissatisfied | Moderately Dissatisfied | Neutral | Moderately Satisfied | Very Satisfied

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

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

On a scale from one to ten, indicate how critical you think your spouse / partner is of you?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not at All Critical | Mildly Critical | Moderately Critical | Quite Critical | Very Critical

On a scale from one to ten, indicate how satisfied you are with the quality of your sexual relationships with your partner?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Dissatisfied | Moderately Dissatisfied | Neutral | Moderately Satisfied | Very Satisfied

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

If cohabitating: Do you plan to cohabit long-term?

○ Yes ○ No ○ Unsure

If “no”, or “unsure”, what are the relevant factors?

V. Children and Family Relationships

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

Do any of your children present special problems to you and / or your spouse / partner? ○ Yes ○ No

If yes, please describe.

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

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

First Name	Last Name	Date

I. Family of Origin

Father	Name	Age
	Occupation	Health
	If deceased, give age at time of death	How old were you at the time?
	Cause of Death	
Mother	Name	Age
	Occupation	Health
	If deceased, give age at time of death	How old were you at the time?
	Cause of Death	
Siblings	Ages of brothers	Ages of sisters
	Where were you in birth order	
	Any significant details about siblings?	

Disruptions in childhood upbringing

Did you experience any significant moves as a child? ○ Yes ○ No

If yes, how old were you?

Did you have significant emotional or behavioral difficulties associated with the move(s)? ○ Yes ○ No

If yes, please describe your difficulties.

Were you ever separated from one or both parents for a significant period of time during your childhood?
○ Yes ○ No

If yes, how old were you?

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?

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

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

What was his attitude toward you as a child?

How much were you able to confide in your father as a child?

How did your father discipline you when you misbehaved?

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

What was her attitude toward you as a child?

How much were you able to confide in your mother as a child?

How did your mother discipline you when you misbehaved?

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

How did your parents get along?

How did the children get along?

What were some of the important spoken or unspoken family rules?

How openly were affection and anger expressed?

How were problems handled?

What were your parents' attitudes about sex? How much was sex discussed in the home?

How involved were your parents in the social interests of the children? How comfortable did you feel having your friends over to the house?

If you have a stepparent, how old were you when your biological parents(s) remarried?

Was religion an important part of your upbringing? ○ Yes ○ No

If yes, in what way was it important?

Did you have any particular fears as a child? ○ Yes ○ No

If yes, what were they?

Which of these, if any do you still have?

II. School / Occupational History

How did you feel about school as you grew up?

Elementary:

High School:

Trade School (if applicable):

College (if applicable):

Post-Graduate Education (if applicable):

How were your grades?

Elementary:

High School:

College:

Post-Graduate Education:

Growing up, were you ever in trouble with the police or school authorities? ○ Yes ○ No

If yes, how old were you at the time?

Describe specific incident(s).

Did you graduate from:

High School ○ Yes ○ No

A vocational training program ○ Yes ○ No

College ○ Yes ○ No

Graduate / Professional School ○ Yes ○ No

Did you take off from school during your education? ○ Yes ○ No

If yes, why?

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

Dates	Job Description	Employer	Reason for Ending

Have you ever made a career change? ○ Yes ○ No

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

III. Social History: Friendships

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

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Difficult | Somewhat Difficult | About Average | Somewhat Easy | Very Easy

As a child (younger than age 13), how difficult was it for you to keep friends?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Difficult | Somewhat Difficult | About Average | Somewhat Easy | Very Easy

About how many close friends did you have as a child?

As an adolescent, how difficult was it for you to keep friends?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Very Difficult | Somewhat Difficult | About Average | Somewhat Easy | Very Easy

About how many close friends did you have as an adolescent?

IV. Social History: Intimate Relationships

At what age did you start dating?

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)

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

If married or cohabitating:

What year did you meet your spouse / partner?

What did you like about him / her / them?

(Optional question): How would you describe your sexual orientation and gender identity?

Thank you for completing this long but important exercise.