DIAGNOSTIC ASSESSMENT

History and Personal Data

Client Name: _____ Date: _____

This questionnaire is designed to help you communicate your experiences, concerns and symptoms with your therapist.

Childhood

DID YOU EVER HAVE ANY OF THE FOLLOWING DIFFICULTIES ***IN CHILDHOOD***? ☐ **None Apply**

- ☐ learning problems
- ☐ problems getting along with others
- ☐ a head injury
- ☐ rejected by those who raised you
- ☐ fighting, arguing
- ☐ leaving a loved one
- ☐ avoiding people or things
- ☐ nervousness or worrying
- ☐ being abandoned, neglected
- ☐ feeling lonely
- ☐ difficulty loving others
- ☐ difficulty making friends
- ☐ rebelliousness
- ☐ high fevers
- ☐ feeling odd or different than others
- ☐ difficulty concentrating
- ☐ excessive energy or restlessness
- ☐ difficulty following rules
- ☐ distressed about future goals
- ☐ fasting or restricting food intake
- ☐ gorging food
- ☐ regurgitating food
- ☐ stuttering
- ☐ urinary incontinence
- ☐ bowel incontinence
- ☐ sleepwalking
- ☐ ongoing nightmares
- ☐ mother or father used drugs
- ☐ mother or father drank too much
- ☐ cruelty to animals
- ☐ behavior problems
- ☐ being physically or sexually abused

Cognition

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING EXPERIENCES? ☐ **None Apply**

- ☐ the world seems cloudy or vague
- ☐ thinking is confused or unclear
- ☐ difficulty paying attention
- ☐ slurred speech
- ☐ judgment is poor
- ☐ headaches
- ☐ not knowing where you are
- ☐ frequently get lost or disoriented
- ☐ hear voices that aren't there
- ☐ see things that aren't there
- ☐ poor memory or forgetfulness
- ☐ irritability or easily frustrated
- ☐ numbness or tingling of skin
- ☐ can't think as quickly as before
- ☐ trouble with "common sense"
- ☐ trouble with reading or writing
- ☐ blurred vision or double vision
- ☐ feeling of unreality
- ☐ unusual body sensations
- ☐ unnecessary suspicions
- ☐ feeling isolated or detached
- ☐ thoughts or actions are controlled by someone else
- ☐ others often don't understand me
- ☐ thoughts can be sensed by others
- ☐ uncontrollable thoughts pop into my mind

Impulsivity

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING STRUGGLES? ☐ **None Apply**

- ☐ stealing/shoplifting
- ☐ overuse of internet
- ☐ excessive spending
- ☐ excessive viewing of pornography
- ☐ having strong feelings of anger
- ☐ gambling
- ☐ infidelity or affairs in relationships
- ☐ high risk sexual behaviors
- ☐ aggressive anger or reactivity
- ☐ periods of rage
- ☐ fire-setting behaviors
- ☐ trouble controlling anger
- ☐ excessive time spent playing video games
- ☐ other impulsive behavior

Safety

DO YOU HAVE ANY WEAPONS IN YOUR HOME? ☐ **None Apply**

☐ Guns ☐ Knives ☐ Other: _____

HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING STRUGGLES? ☐ **None Apply**

- ☐ thoughts about suicide
- ☐ have suicide attempts in the past
- ☐ are you planning to kill yourself?
- ☐ come close to killing yourself?
- ☐ intentionally destroy property
- ☐ damage property in anger
- ☐ violent impulses towards others
- ☐ have specific plans to harm someone
- ☐ engage in physical fights
- ☐ hitting, pushing, intimidating in relationships
- ☐ self-harm behaviors (cutting, burning, etc.)
- ☐ engage in activities with high risk for harm or death

Name:_____

Sleep

DO YOU HAVE ANY OF THE FOLLOWING ***SLEEP-RELATED*** DIFFICULTIES: ☐ **None Apply**

- ☐ trouble going to sleep
- ☐ restless sleep
- ☐ wake up early, cannot return to sleep
- ☐ feel unrested after sleep
- ☐ nightmares / night terrors
- ☐ sleep during the day
- ☐ excessive sleep
- ☐ sleepwalking
- ☐ sleep apnea

Mood

DO YOU HAVE ANY OF THE FOLLOWING ***MOOD-RELATED*** SYMPTOMS? ☐ **None Apply**

- ☐ feeling guilty
- ☐ feeling worthless
- ☐ difficulty concentrating / easily distracted
- ☐ poor memory
- ☐ significant feelings of restlessness
- ☐ loss of pleasure in usual activities
- ☐ have lost zest for life
- ☐ loss of energy or easily fatigued
- ☐ appetite loss
- ☐ emotional eating when not hungry
- ☐ moodiness / irritability
- ☐ weight loss (how much in past month?) ____lbs.
- ☐ weight gain (how much in past month?) ____lbs.
- ☐ feelings of sadness or depression
- ☐ have had periods of time when I feel excited
- ☐ have had periods of time where I did not need very much sleep
- ☐ high focus on goal-directed activities
- ☐ high self-esteem or sense of self
- ☐ very high energy level and very elated
- ☐ times when I talked so fast that people said they could not understand me

Anxiety

DO YOU HAVE ANY OF THE FOLLOWING CONCERNS? ☐ **None Apply**

- ☐ fear of an object, activity or situation which you feel you must avoid, knowing the fear is unreasonable -- the fear seems to control your behavior.
- ☐ fear of being alone in a public place which is difficult to escape from, feeling panicky before you get there
- ☐ feeling humiliated or embarrassed in social situations
- ☐ avoid social situations
- ☐ repeat behaviors or mental acts you feel driven to do
- ☐ fearing health problems the doctor says you don't have
- ☐ feeling panicky in certain situations knowing that it's not reasonable to feel that way -- having physical problems because of it
- ☐ unwanted thoughts, feelings, images or impulses that you can't seem to control, ignore or stop
- ☐ strong need for order, control, or cleanliness
- ☐ worry about a number of situations or events

Please list any specific fears that you have:_____

_____

Please check any of the following problems you experience ***when you are anxious/nervous***.

- ☐ increased heart rate
- ☐ shortness of breath
- ☐ sweating
- ☐ ruminating thoughts
- ☐ racing thoughts
- ☐ feel detached
- ☐ feeling of unreality
- ☐ fear of dying
- ☐ trembling
- ☐ muscle tension
- ☐ chest pain
- ☐ frequent urination
- ☐ dizzy/light-headed
- ☐ cold, clammy hands
- ☐ afraid of losing control
- ☐ sense of dread/panic
- ☐ trouble going to sleep
- ☐ picking skin or hair

Are there times when you have a sudden, intense episode of these symptoms? ☐ Yes ☐ No

If so, how many times per week does this occur?_____

Sexuality

DO YOU HAVE ANY OF THESE ***SEXUALITY-RELATED*** STRUGGLES? ☐ **None Apply**

- ☐ lack of interest in sex
- ☐ not feeling like a member of your sex
- ☐ distress about being attracted to the same sex
- ☐ participating in unusual sexual practices
- ☐ difficulty performing sexual activities
- ☐ cannot enjoy sex
- ☐ feel guilty about sex
- ☐ were sexually assaulted/molested
- ☐ had or have sex problems as a youth
- ☐ high sex drive
- ☐ engage in sexually risky behavior
- ☐ feel a compulsion for sex

Name:_____

Trauma

☐ Have you experienced any recent major change, event, or loss?

☐ Have you experienced a trauma event in which you were exposed to death, possible death, actual or threatened serious injury, or actual or threatened sexual violence?

DO YOU HAVE ANY OF THE FOLLOWING ***TRAUMA-RELATED*** SYMPTOMS? ☐ **None Apply**

☐ feel distressed when reminded of the trauma
☐ have recurring thoughts of the trauma
☐ avoid reminders of the trauma
☐ feel as though the trauma is still present
☐ trauma-related nightmares
☐ chronically tense or "on guard" for danger
☐ unable to recall key aspects of the trauma

Substance Use

DO YOU HAVE ANY OF THESE ***DRUG/ALCOHOL RELATED*** SYMPTOMS? ☐ **None Apply**

☐ binges/run
☐ hangovers
☐ exhaustion
☐ insomnia
☐ headaches
☐ dizziness
☐ seizures
☐ blackouts / loss of time
☐ slurred speech
☐ suicidal thoughts
☐ memory loss
☐ job problems
☐ legal problems
☐ "overamp"
☐ DUI's
☐ depression
☐ vomiting/nausea
☐ delusions/hallucinations
☐ family problems
☐ school problems
☐ physical abuse
☐ accidents
☐ poor coordination
☐ loss of consciousness
☐ paranoia
☐ use despite consequences
☐ drank or used more than intended
☐ attempts to control use / cut down
☐ physically hazardous behavior
☐ a lot of time getting, taking, hiding, coming down
☐ use to avoid withdrawal symptoms
☐ need to use more for same effect
☐ given up social, occupational, recreational activities
☐ promiscuity/sexual dysfunction

Interpersonal

CHECK BELOW ANY PHRASE THAT APPLIES TO YOU ☐ **None Apply**

☐ always on guard/suspicious
☐ difficulty trusting others
☐ feel afraid of others
☐ very hard to be alone
☐ very critical of others
☐ am alone a lot, but prefer this
☐ few close friends
☐ poor body-image
☐ workaholic
☐ hurt easily by rejection
☐ frequent job changes
☐ job-related difficulties
☐ am alone a lot, but dislike this and feel lonely
☐ very dependent on others
☐ feel helpless, lacking self-confidence
☐ oftentimes feel empty
☐ feel more important than others
☐ tend to be selfish
☐ overly sensitive to criticism
☐ difficulty getting along with others
☐ recurring problems with the law
☐ hate being dominated by others
☐ recurring problems in social relationships
☐ recurring problems in intimate relationships
☐ try to do everything perfect
☐ very concerned with details
☐ passive, submissive, non-assertive
☐ most of my friends are online only
☐ often overreact to situations or people with a strong emotional reaction
☐ can't control body movement

DEGREE OF DISTRESS

Please indicate the degree of distress you are experiencing at this time:

☐ minimal ☐ mild ☐ moderate ☐ severe ☐ extreme ☐ catastrophic

In your opinion, are your current problems/concerns:

☐ Life-long difficulties
☐ Ongoing problems that have recently resurfaced
☐ A sudden, recent or acute reaction
☐ Other (please describe):_____