2020 Olive Tree Counseling, Inc.
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Name: _____ Date: _____

Please mark all of the items below that apply. Write in any clarifying remarks

☐ Anger, Rage_____
☐ Anxiety, nervousness, worry _____
_____
_____ I feel restlessness or keyed up on edge frequently _____ I have feelings of irritability
_____ I am easily fatigued _____ I have muscle tension
_____ I have difficulty concentrating or my mind going blank _____ I experience sleep disturbance
_____ I fear or avoid social situations
I have experienced these feelings for _____ 6mo _____1year _____2 years _____since childhood
☐ Attention, concentration, distractibility
☐ Career concerns, goals, and choices
☐ Codependence
☐ Confusion
☐ Custody of children
☐ Decision making, indecision, mixed feelings, putting off decisions
☐ Delusions (false ideas)
☐ Depression _____
_____I feel sad most of the day, nearly every day _____ I feel low energy or fatigue
_____I have a poor appetite, or I overeat _____ I experience feelings of low self esteem
_____I have trouble sleeping or I sleep a lot _____ I experience feelings of hopelessness
_____I have poor concentration or difficulty making decisions _____ I have had a significant weight loss or gain
_____I have feelings of committing suicide _____ I feel like dying
I have experienced these feelings for _____6mo _____1yr _____years _____since childhood
☐ Eating problems – Overeating, under eating, no appetite (see also "Weight and diet issues")
☐ I have used diuretics, laxatives, or induced vomiting ☐ I have been diagnosed with an eating disorder
☐ I have difficulty maintaining my body weight ☐ I eat food for comfort when I am upset or lonely
☐ I am often disturbed by my body's shape or weight ☐ I binge eat
☐ Emptiness
☐ Exercise: How often/What type_____
☐ Envy
☐ Failure
☐ Fatigue, tiredness, low energy
☐ Fears, phobias
☐ Financial or money troubles, debt, impulsive spending, low income
☐ Friendships – None or limited supportive friendships
☐ Forgiveness- I have a difficult time forgiving others
☐ Gambling
☐ Grieving, mourning, deaths, losses, divorce
☐ Guilt
☐ Headaches, other kinds of physical pains_____
☐ Housework/chores - quality, schedules, sharing duties
☐ I pull out my hair and there is noticeable hair loss
☐ I sometimes feel a sense of tension until I pull out my hair and/or I feel a sense of relief after I pull out my hair

☐ Inferiority feelings
☐ Interpersonal conflicts
☐ Impulsiveness, loss of control, outbursts
☐ Irresponsibility
☐ Judgment problems, risk taking
☐ Loneliness
☐ Marital conflict:

____ Distant/coldness	____ Infidelity/Affair	____ Remarriage
____ Disappointments/Discontent	____ Lack of communication	____ Value/Belief System differences
____ Parenting style differences	____ Difference in sexual desire	____ Pornography issues
____Physical or Emotional Intimacy	____ Emotional Neglect or Abuse	____ Domestic Violence

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☐ Memory problems
☐ Menstrual problems, PMS, menopause
☐ Mood swings
☐ Motivation, laziness
☐ Obsessions/ Compulsions

_____I have recurrent or persistent thoughts	_____I experience images or impulses that are intrusive
_____I feel anxiety	_____I ignore or suppress thoughts, urges, or images
_____I repeat behaviors (i.e. washing hands, checking, ordering)	_____I experience anxiety if I don't repeat behaviors

☐ Oversensitivity to rejection
☐ Panic or anxiety attacks
_____palpitations, pounding of or increased heart rate ____Sweating ____trembling or shaking ____nausea ____fear
_____shortness of breath _____feeling of choking ____chest pain/discomfort ____dizziness ____fear of losing control
☐ Parenting, child management, single parenthood
☐ Perfectionism
☐ Pessimism
☐ Pregnancies: How many_____ Losses_____ Terminations _____ Difficulties _____
☐ Problems associated with prescriptions medications, over-the-counter medications
☐ Procrastination, work, inhibitions, laziness
☐ Relationship problems (with friends, with relatives, or at work)
☐ Self-centeredness
☐ Self-esteem, Self-neglect, poor self-care
☐ Sexual issues, dysfunctions, conflicts, desire differences
☐ Shyness, oversensitivity to criticism
☐ Sleep problems—too much, too little, insomnia, nightmares
☐ Smoking and tobacco use
☐ Sometimes I see or hear things others do not hear or see
☐ Spiritual, religious, moral, ethical issues
☐ Stress, relaxation, stress management, stress disorders, tension
☐ Suspiciousness
☐ Suicidal thoughts: Describe_____
Suicide attempt: Describe_____
Homicidal thoughts or attempts: Describe_____
☐ Temper problems, self-control, low frustration tolerance
☐ Thought disorganization
☐ Threats, violence
☐ Withdrawal, isolating
☐ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
☐ No one could really love me as I am
☐ I must be right or perfect to be ok

☐ I am basically a bad, unworthy person
☐ Internet use: How much time/day do you engage in _____gaming _____surfing _____Surfing _____Facebook/blogging
☐ Sex is my most important need or sign of love
☐ My needs are never going to be met if I have to depend on others
☐ I have trouble with authority figures
☐ I dislike taking instructions or having someone tell me what to do
☐ I have in the past or am currently cutting myself
☐ Alcohol or drug use over the past 12 months:
  ☐ Have you gotten into trouble at home, at school or in the community, because of your drinking, using drugs or inhalants?
  ☐ Have you missed school or work because of using alcohol, drugs or inhalants?
  ☐ In the past year have you ever had 6 or more drinks at any one time?
  ☐ Have you done harmful or risky things when you were high?
  ☐ Do you think you might have a problem with your drinking, drug or inhalant use?
  ☐ When using alcohol, drugs or inhalants have you done things without thinking, and wished you had not done them later?
  ☐ Do you miss family activities, after school activities, community events, traditional ceremonies, potlatches, or feasts because of using alcohol, drugs or inhalants?
  ☐ Does anyone close to you worry or complain about your using alcohol, drugs or inhalants?
  ☐ Have you lost a friend or hurt a loved one because of your using alcohol, drugs or inhalants?
  ☐ Do you use alcohol, drugs or inhalants to make you feel normal?
  ☐ Does it make you mad if someone tells you that you drink or use drugs or inhalants too much?
  ☐ Do you feel guilty about your alcohol, drug or inhalant use?

Medical: Personal and Family of Origin

Name of Personal Family Physician _____

☐ Do you have any allergies? No Yes if yes, please describe_____

☐ How would you describe your health/medical status? Excellent good fair poor

☐ Please describe any chronic / current medical conditions_____

_____

Please list any medications you are taking for these conditions_____

_____

☐ Please describe any past or present psychiatric, counseling or drug / alcohol treatment you have received

When/Dates	From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ Please list any psychiatric medications you have taken in past or are currently taking

Medication Name	When/From Whom?	For What?	With What Results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ I am at low medium high risk for HIV ☐ I am at low medium high risk for Hepatitis
☐ I have been diagnosed with TB ☐ I have been treated for TB
☐ I have had a blow to the head that caused me lose consciousness ☐ I have had a blow to the head that caused a concussion
☐ I have received an injury that caused vision and / or hearing loss
☐ Did your father or his parents have any medical or psychological problems? No Yes if yes, please describe

_____

☐ Did your mother or her parents have any medical or psychological problems? No Yes if yes, please describe

_____

Your Children:

Name	Gender	Age	Who do they live with	Describe your relationship with them
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

Family History:

1. Where were you born and raised? How many siblings do you have?
   _____
2. Which of these words best describes your relationship with your parents as a child?
   Mother: ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Father: ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic

3. Which of these words best describes your relationship with your Siblings?
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic
   Name of sibling: _____ ___ Warm ___Loving ___Distant ___Difficult ___Supportive ___Bonded ___Attached ___Chaotic

4. List two positive things your parents taught you when you were growing up: _____
5. List two negative things your parents taught you: _____
6. Did a parent or other adult in the household often … Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Who? _____ _____ Yes _____No
7. Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Who? _____ _____Yes _____No
8. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Try to or actually have oral, anal, or vaginal sex with you? Who? _____ _____ Yes _____ No
9. Did you often feel that… no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other? _____Yes _____No
10. Did you often feel that… you didn't have enough to eat, had to wear dirty clothes, had no one to protect you Or your parents were too drunk or high to care for you or take you to the doctor if needed? _____Yes _____No
11. Were your parents ever separated or divorced? How old were you? ____ _____Yes _____No
12. When you were a child were any of your caregivers treated violently, often pushed, grabbed, slapped, had something thrown at them, kicked, bitten, hit with a fist, or hit with something hard; or threatened with a gun or knife? Who? _____ _____Yes _____No
13. Did you live with anyone who was a problem drinker or used street drugs? Who? _____ _____Yes _____No
14. Was a household member depressed or mentally ill or did a household member attempt suicide? Who? _____ _____Yes _____No
15. Did a household member go to prison? Who? _____ _____Yes _____No

Additional Lifetime losses / Adult OR Teen Traumas NOT previously noted.(Briefly describe)

____ Abandonments _____
____ Assaults / Violent Events (including date or stranger rape)_____
_____
____ Betrayals_____
____ Deaths_____
____ Separation or Divorces (How many? Briefly describe cause) _____
_____
____ Threats / Intimidation (Briefly describe)_____

☐ Please comment on any additional information In space below