

DONNA JANTZ, MA, LPC, LLC

QUESTIONNAIRE

Date _____
Name _____ Date of Birth _____
Address _____ City _____ State _____ ZIP _____
Phone: Home _____ Work _____ Email _____
Age _____ Occupation _____ Religion _____
Height _____ Weight _____
With whom are you living? _____ How long? _____
Marital Status: Never married ___ First Marriage ___ Remarried ___ Separated ___
Divorced ___ Widowed ___ Cohabiting ___ Engaged ___
How strongly do you want treatment for your problem?
Very much _____ Moderately _____ Could do without if necessary _____

List present medications and purposes:

Have you ever been in therapy before? Yes ___ No ___
Have you ever been hospitalized for psychological/psychiatric problems? Yes ___ No ___
Have you ever attempted suicide? Yes ___ No ___
Does any member of your family suffer from alcoholism or "mental disorder"? Yes ___ No ___
Has any relative attempted or committed suicide? Yes ___ No ___

Clinical Information:

State in your own words the nature of the problem for which you is seeking help.

Give a brief account of the history and development of your problem from onset until the present.

Underline any of the following physical sensations that apply to you:

- | | | | |
|-------------|--------------------|-------------------|-----------------|
| Headaches | Stomach trouble | Skin Problems | Dizziness |
| Tics | Dry mouth | Palpitations | Fatigue |
| Flushes | Muscle spasms | Twitches | Chest pains |
| Tension | Back pain | Rapid heartbeat | Sexual problems |
| Tremors | Touch aversion | Unable to relax | Fainting spells |
| Blackouts | Hear things | Bowel disturbance | excess sweating |
| Tingling | Visual disturbance | Watery eyes | Numbness |
| No appetite | Nail biting | Feel lonely | Inferiority |

Underline any of the following that applied during your childhood/adolescence:

Night Terrors	Bed Wetting	Sleep walking	Thumb sucking	Nail biting
Stammering	Fears	Happy/Unhappy childhood	School problems	Medical problems
Family problems	Alcohol abuse	Drug abuse	Legal trouble	Physical abuse
Emotional abuse	Incest	Emotional/behavioral problems		

Age of starting work. _____

Jobs held (in chronological order) and reasons for change

Underline any of the following Behaviors that apply:

Overeat	Suicidal attempts	Can't keep job	Loss of control
Take drugs	Smoke	Insomnia	Aggressive
Vomit	Withdrawal	Lazy	Avoidance
Odd behavior	Risky behavior	Nervous tics	Temper problem
Drink too much	Problems concentrating	Eating problems	Procrastinate
Overwork	Sleep disturbance	Crying	Impulsivity

Are there any specific behaviors, actions or habits you would like to change? _____

What special talents or skills are you good at? _____

Underline any of the following feelings that apply:

Angry	Guilty	Unhappy/Happy	Envious
Annoyed	Bored	Sad	Jealous
Depressed	Conflicted	Restless	Tense
Anxious	Hopeless	Excited	Relaxed
Panicky	Helpless	Optimistic	Other _____

Underline each of the following thoughts that apply:

I am worthless, a nobody, useless and /or unlovable.

I am unattractive, incompetent, stupid and /or undesirable.

I am evil, crazy, a waste, degenerate and/or deviant.

Life is empty: there is nothing to look forward to.

I make too many mistakes, can't do anything right.

Sex Information:

Parental attitudes towards sex: (i.e. was there sex instruction or discussion) _____

How and when did you derive your first knowledge of sex? _____

When did you first become aware of your own sexual impulses? _____

Please, provide information about any significant heterosexual and/or homosexual relations _____

Marital History:

How long did you know your spouse before engagement? _____

How long were you engaged? _____

Your spouse's Age _____ Occupation _____

In what ways are you compatible? _____

In what ways are you incompatible? _____

How do you get along with in-laws? _____

List your children's names and ages. State if any from previous marriage. List miscarriages.

Give details of any previous marriage(s).

Family Data:

Father's name and age _____

If deceased, cause of death _____

Health _____

Describe Father's personality and his attitude toward you (past and present) _____

Mother's name and age. _____

If deceased, cause of death _____

Health _____

Mother's condition during pregnancy (as far as you know). _____

Describe Mother's personality and her attitude toward you (past and present) _____

Sibling's names and ages and if single, married, divorced, etc. _____

Surgeries (List them and give age at the time of each)

Were you involved in any accidents (Indicate your age at the time and any injuries you sustained)? _____

When was the last time you felt well, physically and emotionally for a sustained period? _____

How is most of your free time occupied? _____

Do you make friends easily? _____ Do you keep them? _____

Describe your home atmosphere growing up. (Compatibility between parents/parents and siblings) _____

Recount any fearful or distressing experiences not previously mentioned. _____

Complete the following:

I could shock you by _____

A mother should _____

A father should _____

A true friend should _____

How would others describe you? _____

How would others describe you? _____

Please, feel free to use the backside of this sheet to elaborate on any subject matter that may be helpful.