THE CENTER FOR MODERN FAMILY DYNAMICS

Identification Information

Name: _____ Age: _____ DOB: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

County: _____ E-Mail:_____

Is it O.K. to contact you at this number?

Yes No

It is customary practice of Modern Family Dynamics to mail a letter of termination at the end of treatment. If the above is not a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address:

_____

PRESENT PSYCHOLOGICAL STATUS

Please describe your reason for seeking help		_____
❑ Yes	❑ No	Have you ever seen a counselor or mental health worker before?
		← Why were you seeking help?
❑ Yes	❑ No	← Was the counseling beneficial?
		← Who was the counselor?
❑ Yes	❑ No	Have you ever been hospitalized for any emotional or psychological difficulties?
		← What was the concern?
❑ Yes	❑ No	Does anyone in your family have emotional or psychological problems?
❑ Yes	❑ No	Is there anything currently bothering you or causing you to worry?
❑ Yes	❑ No	Are you having disturbances or difficulty with your sleep?
❑ Yes	❑ No	Have you experienced any changes in appetite recently?
❑ Yes	❑ No	Have there been any sudden changes with your weight?
❑ Yes	❑ No	Do you have any health problems (diabetes, heart problems, etc)?
❑ Yes	❑ No	Do you experience times when your heart races and you become short of breath?
❑ Yes	❑ No	Are you having headaches or migraines?
❑ Yes	❑ No	Are you experiencing any stomach problems?
❑ Yes	❑ No	Do you have any problems with depression?
❑ Yes	❑ No	Any suicidal thoughts or attempts? (past or present)
❑ Yes	❑ No	Do you have any unwanted thoughts that you can not seem to get rid of?
❑ Yes	❑ No	Any problems related to thinking, concentrating, or memory?
❑ Short ❑ Medium ❑ Long		How would you rate your temper (fuse)?

FAMILY AND PERSONAL DEMOGRAPHICS

Spouse/Significant Other			Name: _____ Age: _____
(If married) Spouse's age at marriage: _____			Occupation: _____
❑ Yes	❑ No		Has your partner been married previously?
❑ Yes	❑ No		Is your partner's occupation a source of conflict in your marriage?
❑ Yes	❑ No		Do you have any children?
Name(s): _____			Age(s): _____
_____			_____
_____			_____
❑ Good	❑ Fair	❑ Poor	What kind of relationship do you have with your child(ren)?
❑ Good	❑ Fair	❑ Poor	What kind of relationships do your children have with each other?
			If married, how many years have you been married (current marriage)?
			What was your age when you married (current marriage)?
❑ Yes	❑ No		Have you been married previously?
❑ Good	❑ Fair	❑ Poor	How would you describe your current marriage?
❑ Yes	❑ No		Do you have family members that live in the immediate area?
❑ Mother	❑ Father	❑ Sibling(s) ❑ Grandparent(s) ❑ Inlaw(s)	
❑ Good	❑ Fair	❑ Poor	How well do you like your living arrangements?
❑ Good	❑ Fair	❑ Poor	Are you able to keep up with your normal chores and responsibilities?
Yes	No		Do you find it difficult to remain focused or attentive with tasks?
❑ Good	❑ Fair	❑ Poor	Are you satisfied with your career/employment?
❑ Yes	❑ No		Is your occupation/employment a source of conflict with your partner?
❑ Yes	❑ No		Do you have any hobbies or other interests?
			←What kind of hobbies?
❑ Yes	❑ No		Lately, have you seemed to lose interest in things that normally bring you pleasure?
❑ Yes	❑ No		Do you have an individual with whom you can share problems or worries (confide)?
❑ Yes	❑ No		Do you care for any pet(s)?
			←What kind of pet(s)?

CHILDHOOD AND FAMILY OF ORIGIN

❑ Yes	❑ No	Do you have any brothers or sisters?

Name(s): Age(s): Occupation(s):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

❑ Good	❑ Fair	❑ Poor	As a child, how did you get along with your brothers/sisters?
❑ Good	❑ Fair	❑ Poor	At present, how do you get along with your brothers/sisters?

What was your father like?

_____

_____

❑ Good	❑ Fair	❑ Poor	What kind of relationship did you have with your father?

What was your mother like?

_____

_____

❑ Good	❑ Fair	❑ Poor	What kind of relationship did you have with your mother?
❑ Good	❑ Fair	❑ Poor	What kind of relationship did your parents have with each other?

As a child, how did you know that your parents loved you?

_____

_____

As a child, how did you know that your parents loved each other?

_____

_____

❑ Yes	❑ No	Are your parents divorced?
		←How old were you when this happened?
❑ Yes	❑ No	Were you ever abused as a child?
❑ Good	❑ Fair ❑ Poor	How would you describe your health during childhood?
❑ Nailbiting ❑ Bedwetting ❑ Temper tantrums ❑ Running away ❑ Fears ❑ Nightmares ❑ Thumbsucking ❑ Other		Any childhood habits?
❑ Yes	❑ No	Did you get into any trouble as a child?
10 9 8 7 6 5 4 3 2 1 GOOD POOR		How would you characterize your overall childhood?

EDUCATION AND WORK HISTORY

❑ Did not complete high school ❑ High school graduate ❑ College Graduate ❑ Completed vocational/ technical school			Which best describes your educational experience
❑ Yes	❑ No		Are you currently in school?
			←If yes, where are you enrolled?
❑ Yes	❑ No		Did you receive any awards or honors in school?
❑ Yes	❑ No		Were you involved in any extra-curricular activities (band, sports, etc)?
❑ Yes	❑ No		Do you have any learning problems or complications?
❑ Above Average ❑ Average ❑ Below Average			What kind of grades did you receive in school?
Good	Fair	Poor	How did you get along with your classmates?
Good	Fair	Poor	How well did you relate with your teachers?
Yes	No		Were you ever in the military?
			←What branch did you serve in?
			←What was your job/specialty?
			← How long did you serve?
Yes	No		Are you currently employed?
Enjoy	It's OK	Dislike	Do you enjoy your present work situation?
Yes	No		Do you have any special job skills or training?
Good	Fair	Poor	How well do you get along with your boss/supervisor?
Good	Fair	Poor	How well do you get along with your co-workers?
Yes	No		Do you have any problems with being late or absent to work?
Yes	No		Have you experienced any accidents or losses while working?
Yes	No		Have you ever been fired from a job before?

Previous jobs you have held? How long at job

(1) _____

(2) _____

Yes	No	Do you have enough money to pay your bills?
Yes	No	Do you have own or have access to a car?

General Health

		Who is your family physician?
		When was the last time you saw a physician (approximate)?
Yes	No	Are you currently taking any medications?
		← If yes, please list the medications
Yes	No	Have you ever been prescribed sedatives to help you sleep?
Yes	No	Have you ever been prescribed medication to help with depression?
Yes	No	Are you allergic to any medications?
Yes	No	Do you drink (alcohol) on a regular basis?
Yes	No	Do you smoke?
Yes	No	Have you ever taken/used any illegal drugs? (If yes please indicate)
	Cocaine/Crack	Amphetamines (speed) PCP (Angel dust)
	Marijuana	Hallucinogens (LSD, Peyote, "magic mushrooms")
	Inhalants (gas, glues, thinners)	Heroin (morphine)
Yes	No	Do you have any sexual concerns?
GOOD 10 9 8 7 6 5 4 3 2 1 POOR		How would you rate your current overall health? (please circle)

SPIRITUAL INVENTORY

What relationships have the greatest influence in your life right now?

_____

_____

Yes No 1) 2)	Are there any persons from your past that have played a significant part in shaping your view of life? (If yes, please list each)
Yes No	Has there been an event in your life (either positive or negative) which was so intense that it permanently affected your outlook on life? (If yes, please describe briefly)

_____

_____

_____

What beliefs or values have been most important in guiding your life?

_____

_____

What feelings or emotions do you have when you think of God; is there any particular image that comes to mind?

_____

_____

Yes, a lot Somewhat Not at all	Is your faith/spirituality helpful to you?

Is there anything you do to help nurture or maintain your faith/spirituality?

_____

_____

Consistent Inconsistent Almost never		How successful are you in regularly maintaining these practices?
Yes	No	Are there any conflicts between your beliefs and your partner's beliefs?
Yes	No	Are there any conflicts between your beliefs and anything you are presently doing? (sexually, morally, etc.)
Yes	No	Do you believe you have committed an unpardonable sin?

CURRENT STATUS

Please answer the following questions so that we might have a better idea of how you are doing (circle the correct number):

	Not at all			Some			A lot
During the past week, how concerned or worried have you been about your health?	1	2	3	4	5	6	7
During the past week, how anxious, nervous, or tense have you been?	1	2	3	4	5	6	7
During the past week, how much have you been bothered by feelings of guilt?	1	2	3	4	5	6	7
During the past week, have you felt super-efficient or like you have unlimited energy, special talents or powers?	1	2	3	4	5	6	7
During the past week, how depressed have you felt?	1	2	3	4	5	6	7
During the past week, how irritable or angry have you been?	1	2	3	4	5	6	7
During the past week, how much distrust of others have you felt (or how much did it seem like others were out to hurt you)?	1	2	3	4	5	6	7
During the past week, did you hear or see things around you that others did not see?	1	2	3	4	5	6	7
During the past week, how much difficulty have you had with your thinking?	1	2	3	4	5	6	7