

Marital Status (more than one answer may apply)

Sexual Orientation: _____

- Single Domestic partner Legally married
- Separated Divorced Widowed
- Other (please describe) _____

Total number of marriages: _____

Assessment of current relationship (if applicable): _____ Good _____ Fair _____ Poor

Parental Information

- Parents legally married Mother remarried: Number of times: _____
- Parents have ever been separated Father remarried: Number of times: _____
- Parents ever divorced

Special circumstances (e.g., raised by person other than parents, information about spouse/children not living with you, etc.): _____

Development

- Has there been history of child abuse? Yes No
- If Yes, which type(s)? Sexual Physical Verbal
- If Yes, the abuse was as a: Victim/Survivor Perpetrator
- Other childhood issues: _____ Neglect _____ Inadequate nutrition
- Other (please describe): _____
- Comments re: childhood development: _____

Social Relationships

- Check how you generally get along with other people: (please check all that apply)
- Affectionate Aggressive Avoidant Fight/argue often Follower
- Friendly Leader Outgoing Shy/withdrawn Submissive
- Other (specify): _____
- Sexual issues? _____ Yes _____ No
- If Yes, please describe: _____
- Any current or history of being as sexual abuse perpetrator? Yes No
- If Yes, please describe: _____

Cultural

- To which cultural or ethnic group(s) do you belong?
- _____
- _____
- Are you experiencing any problems due to cultural issues? _____ Yes _____ No
- If Yes, please describe: _____
- _____
- Other cultural/ethnic information you would like me to know prior to beginning therapy: _____
- _____
- _____
- _____

Spiritual/Religious

How important to you are spiritual/religious matters? ___ Not ___ Little ___ Moderate ___ Much

Are you affiliated with a spiritual or religious group? _____ Yes _____ No

If Yes, please describe: _____

Were you raised within a spiritual or religious group? _____ Yes _____ No

If Yes, please describe: _____

Would you like your spiritual/religious beliefs incorporated into therapy? _____ Yes _____ No

If Yes, please describe: _____

Legal

Current Status

Are you involved in any active cases (traffic, civil, criminal)? ___ Yes ___ No

If Yes, please describe and indicate the court and hearing/trial dates and charges: _____

Are you presently on probation or parole? ___ Yes ___ No

If Yes, please describe: _____

Past History

Traffic violations: ___ Yes ___ No

DWI, DUI, etc.: ___ Yes ___ No

Criminal involvement: ___ Yes ___ No

Civil involvement: ___ Yes ___ No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Education

Fill in all that apply: Years of education: _____ Currently enrolled in school? ___ Yes ___ No

___ High school grad/GED

___ Vocational: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ College: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

___ Graduate: Number of years: ___ Graduated: ___ Yes ___ No Major: _____

Other training: _____

Special circumstances (e.g., learning disabilities, gifted): _____

Employment

Begin with most recent job, list job history:

Employer	Dates	Title	Reason left job?	How often miss work?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Currently: _____ FT _____ PT _____ Temp _____ Laid-off

_____ Disabled _____ Retired _____ Social Security _____ Student

Other (describe): _____

Military

Military experience? Yes No Combat experience? Yes No
 Where: _____
 Branch: _____ Discharge date: _____
 Date drafted: _____ Type of discharge: _____
 Date enlisted: _____ Rank at discharge: _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Measles | <input type="checkbox"/> Toothache |
| <input type="checkbox"/> Colds/Coughs | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mumps | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Other (describe): _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea | _____ |

List any current health concerns: _____

List any recent health or physical changes: _____

Current prescribed medications	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the-counter meds	Dose	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications or drugs? Yes No

If Yes, please describe: _____

	Date	Reason	Results
Last physical exam	_____	_____	_____
Last doctor's visit	_____	_____	_____
Last dental exam	_____	_____	_____
Most recent surgery	_____	_____	_____
Other surgery	_____	_____	_____
Upcoming surgery	_____	_____	_____

Family history of medical problems: _____

Please check if there have been any recent changes in the following:

Sleep patterns Eating patterns Behavior Energy level
 Physical activity level General disposition Weight Nervousness/tension

Describe changes in areas in which you checked above: _____

Chemical Use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hours		Used in last 30 days	
					Yes	No	Yes	No
Alcohol	_____	_____	_____	_____	_____	_____	_____	
Barbiturates	_____	_____	_____	_____	_____	_____	_____	
Cocaine/Crack	_____	_____	_____	_____	_____	_____	_____	
Heroin/Opiates	_____	_____	_____	_____	_____	_____	_____	
Marijuana	_____	_____	_____	_____	_____	_____	_____	
Caffeine	_____	_____	_____	_____	_____	_____	_____	
Nicotine	_____	_____	_____	_____	_____	_____	_____	
Over the counter	_____	_____	_____	_____	_____	_____	_____	
Prescription drugs	_____	_____	_____	_____	_____	_____	_____	

Substance(s) of preference (most to least)

1. _____
2. _____
3. _____
4. _____

Substance Questions

Reason(s) for use:

Addicted Build confidence Escape Self-medication
 Socialization Taste Other (specify): _____

How do you believe your substance use affects your life? _____

Does/Has someone in your family present/past have/had a problem with drugs or alcohol?

Yes No If Yes, please describe: _____

Counseling/Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where	Your reaction to overall experience
Counseling/Psychiatric	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____
12-Step self-help groups	___	___	_____	_____	_____

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

- | | | |
|--|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Elevated mood | <input type="checkbox"/> Phobias/fears |
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Recurring thoughts |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Gambling | <input type="checkbox"/> Sexual addiction |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Sick often |
| <input type="checkbox"/> Avoiding people | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Cyber addiction | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Thoughts disorganized |
| <input type="checkbox"/> Disorientation | <input type="checkbox"/> Judgment errors | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Distractibility | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Withdrawing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Memory impairment | <input type="checkbox"/> Worrying |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Mood shifts | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Panic attacks | _____ |

Briefly discuss how the above symptoms impair your ability to function effectively: _____

Any additional information that would assist me in understanding your concerns or problems: _____

What are your goals for therapy? _____

Do you feel suicidal at this time? Yes No

If Yes, explain: _____

Where did you first learn about Dr. Martarella's psychotherapy practice?

Signature: _____ **Date:** _____

