I. Which of the following feelings or symptoms are you having which are connected with your coming to counseling. (Please check as many as apply

Yes	No		Yes	No		Yes	No	
		Anxiety			Guilt Feelings			Relationship pro
		Arguments			Hallucinations			Sexual problems
		Crying			Insecurity			Sleep problems
		Confusion			Marital problems			Tension
		Delusions			Memory lapses			Weight problems
		Depression			Mood swings			Other (describe):______
		Difficulty Concentrating			Problems with child			

Is there a history of:

Yes	No		Yes	No		Yes	No	
		Abuse by parents			Fighting			Alcohol abuse
		Abuse by spouse			Arrests			Drug abuse
		Abuse of spouse			Runaway			Glue sniffing
		Abuse of children			Abuse of others			Poor school perf ance
		Divorce			Abuse of animals			School drop-out
		Family conflict			Medical problems			Special educatio placement
		Conflict with siblings			Self-mutilation			
					Suicide attempts			
		Marital problems			Suicidal thoughts			Truancy
		Financial problems			Housing problems			Tantrums
		Problems on job			Self abuse			Other school pro
		Unemployment						

II. GENERAL BACKGROUND:

Birthdate:______________ Place:____________________State/County:__________

Parent's marital status: Married___ Divorced___ Separated ___ Other___

FAMILY OF ORIGIN:

	Name	Age	Occupation
Father			
Mother			
Stepmother			
Foster Father			
Foster Mother			
Siblings (Brothers and sisters)			