# *Brightway Counseling & Wellness*

***This will take about 15-20 minutes to complete. Please allow time to accurately answer these questions.**

## Comprehensive Assessment Questionnaire

**Name: _____ Date: _____**

What are the main problems or symptoms that caused you to seek help now? _____
_____
_____

Describe any stresses in your life that may have contributed to the problem: _____
_____
_____

Describe the history of the problem from its onset until now: _____
_____
_____

Have you had a similar problem in the past? __ Yes __ No If so, please describe the episodes and the dates they occurred. _____
_____

Were you treated for this problem? __Yes __No If so, please describe the treatment you received.
_____
_____

Has this problem caused you to experience any decrease in your ability to function in the following areas? If so, please describe:
School performance: _____

Work performance: _____

Relationship with spouse/significant other: _____

Functioning as a parent: _____

Social life: _____

Ability to manage chores at home: _____

**Medical History**
Please list all medications you are currently taking:
Prescription Medication Dose Start Date (MMYY)
_____
_____
_____
_____

Please list any health problems: _____

**Mental Health History**

Please list any Psychiatrist/Psychologist/Therapist you have seen previously:

| Name | Dates Seen | Reason | Medications Prescribed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever attempted suicide? __Yes __No If yes, please describe the nature of the event and the date(s) of occurrence. _____

_____

Please list any blood relatives who have any history of mental or emotional problems (e.g. depression, manic depression, alcoholism, drug abuse, suicide, schizophrenia, anxiety problems, eating disorders, Attention Deficit Disorder, etc.)

| Relative | Problem |
|---|---|
| | |
| | |
| | |

Substance Use:

Do you use any of the following?

| Substance | Yes | No | Amount Frequency: | Daily | Weekly | Date last used |
|---|---|---|---|---|---|---|
| Tobacco | __ | __ | _____ | __ | __ | _____ |
| Caffeine | __ | __ | _____ | __ | __ | _____ |
| Alcohol | __ | __ | _____ | __ | __ | _____ |
| Marijuana | __ | __ | _____ | __ | __ | _____ |
| Cocaine | __ | __ | _____ | __ | __ | _____ |
| Amphetamines | __ | __ | _____ | __ | __ | _____ |
| LSD | __ | __ | _____ | __ | __ | _____ |
| Heroin | __ | __ | _____ | __ | __ | _____ |
| Pain killers | __ | __ | _____ | __ | __ | _____ |
| IV Drug Use | __ | __ | _____ | __ | __ | _____ |

Have you ever felt that you were abusing drugs or alcohol? __ Yes __No If so, please describe when and the nature of the problem. _____

_____

Have you tried to stop drinking? __ Yes __ No If yes, what was the outcome? _____

_____

Have you ever attended AA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings? _____

Have you ever attended NA? __ Past __ Current If yes, do you have a sponsor and how often do you attend meetings? _____

**Family/Social History**

Where were you born and raised? _____

Please list your siblings and their current ages: _____
_____

Are you close to your siblings? _____

How would you describe your relationship with your father? _____
_____

How would you describe your relationship with your mother? _____
_____

Describe your childhood: _____
_____

Were your parents divorced? __ Yes __ No If yes, how old were you? _____

With whom did you live after the divorce? _____

Did your mother remarry? __ Yes __ No Did your father remarry? __ Yes __ No

What was your relationship like with the stepparent(s)? _____
_____

Were you ever subjected to any type of abuse (emotional, physical, sexual)? __ Yes __ No

If yes, please describe the events and ages the abuse occurred. _____
_____

Have you lost a close family member or friend? __ Yes __ No Who? _____ When? _____

**Educational History**
Did you complete high school? __ Yes __ No

What kind of grades did you receive in school?_____

How did you get along with your peers? _____

How did you get along with your teachers? _____

Did you attend college? __ Yes __ No

Where? _____ Degree? _____

**Occupational History**
Are you currently working? __ Yes __ No What is your occupation? _____

What is your current position? _____

Where do you work? _____ How long have you been there?_____
Are you satisfied with your job? __Yes __ No If no, explain: _____

Describe any current job stresses you may be experiencing: _____
_____

How well do you get along with your co-workers? _____

How well do you get along with your supervisors? _____

List your last two jobs and how long you worked there: _____
_____

**Relationship History**
Are you currently __ Single __ Married __ Divorced __ Widowed __ Living Together

How long? _____ What is your sexual orientation? _____

Describe your relationship with your spouse or significant other: _____
_____

List any stresses or problems in your relationship: _____
_____

If married, what is your spouse's occupation? _____

Have you been married before (or in a long-term committed relationship)? __ Yes __ No

How many times? _____ How long did these relationships last? _____

Please describe the reason for the break-up or divorce: _____

If you have children, what are their names and ages? _____
_____
Describe any problems you may be experiencing with your children: _____
_____

What is your religious preference? _____

How often do you attend religious services? _____ Where? _____

Any hobbies?:_____

Is there any other important information about you that has not been covered, which you feel the therapist should know? _____

****Please complete the attached symptom checklist below**

# *BrightWay Counseling & Wellness*

**Symptom Checklist**

*Check all that apply. Then circle items that are especially bothersome to you.*

Recent Past

1. Please check any of the following which may have been particularly stressful to you:

___ ___ Job related stress

___ ___ Marital conflict

___ ___ Death or loss of loved one

___ ___ Move to a new place and losing contact with friends or family

___ ___ Conflict with children

___ ___ Children with behavior problems

___ ___ Conflict with parents or extended family

___ ___ Feeling stress due to recalling memories of trauma or stress in my life

___ ___ Family member with an alcohol or drug problem

___ ___ Being abused by someone

___ ___ Financial pressure

2. Any of the following symptoms for most of the day, nearly every day, for periods longer than several days at a time:

___ ___ Depressed or sad mood

___ ___ Loss of interest or pleasure in things I'm normally interested in

___ ___ Difficulty falling asleep

___ ___ Difficulty staying asleep or waking up too early

(average number of hours you are sleeping per night? _____)

___ ___ Sleeping too much

___ ___ Increased appetite/weight gain (lbs._____)

___ ___ Decreased appetite/weight loss (lbs. _____)

___ ___ Fatigue/Poor energy level

___ ___ Decreased activity (work, social, physical, sexual)

___ ___ Poor concentration or slowed thinking

___ ___ Thoughts of suicide

___ ___ Excessive feelings of guilt or worthlessness

___ ___ Decreased sex drive or interest

3. Any of the following symptoms, more days than not, for months at a time:

___ ___ Excessive anxiety or worry for no good reason

___ ___ Trembling, twitching or feeling "shaky"

___ ___ Muscle tension or muscle aches

___ ___ Easily fatigued

___ ___ Dry mouth

Recent Past

___ ___ Dizziness or lightheadedness

___ ___ Nausea, diarrhea or other stomach problems

___ ___ Frequent urination

___ ___ Feeling keyed up or on edge

___ ___ Irritability

___ ___ Trouble falling or staying asleep

4. Panic attacks (any period of extreme, increased anxiety lasting from a few minutes up to several hours) with any of the following symptoms:

___ ___ Panic attacks/anxiety attacks

___ ___ Persistent worry that I will have a panic attack

___ ___ Heart pounding or racing heart

___ ___ Trembling or shaking

___ ___ Sweating

___ ___ Choking

___ ___ Nausea or stomach problems

___ ___ Feelings of unreality

___ ___ Numbness or tingling sensations

___ ___ Feeling of smothering or shortness of breathe

___ ___ Fear of dying

___ ___ Fear of going crazy or doing something uncontrolled

___ ___ Chest pain or discomfort

___ ___ Dizziness, unsteady feelings or faintness

___ ___ Flushes, hot flashes or chills

___ ___ Avoiding situations or places that may cause panic or severe anxiety

5. Any of the following symptoms for <u>most of the day, nearly every day, for more than four days at a time:</u>

___ ___ Euphoric or "high" mood

___ ___ Irritable mood

___ ___ Decreased need for sleep without feeling tired

___ ___ Increased energy level

___ ___ Increased activity (work, social, physical, sexual)

___ ___ Thoughts speeded up or racing thoughts

___ ___ Increased talkativeness or being much more socially outgoing

___ ___ Making decisions too impulsively

___ ___ Going on spending sprees

Recent Past

6. Check any of the following relating to your alcohol or drug use:

___ ___ I've felt alcohol or drugs were causing a problem for me

___ ___ I have felt guilty about my use

___ ___ Others have annoyed me about my use

___ ___ I have had a desire (or made unsuccessful efforts) to cut down or control my use

___ ___ I've tried unsuccessfully to control my use

___ ___ I've used alcohol or drugs more often or in larger amounts than I intended

___ ___ I've had to increase my use of alcohol or drugs to get the desired effect

___ ___ I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down or stopped using alcohol or drugs

___ ___ I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous

7. Any of the following disturbances in eating or maintaining normal weight:

___ ___ Insistence on maintaining body weight below expected for age and height

___ ___ Intense fear of gaining weight or becoming fat even though underweight

___ ___ I feel "fat" even when others see me as underweight

___ ___ Eating binges

___ ___ Feeling of lack of control of eating during eating binges

___ ___ Vomiting or using laxatives to prevent weight gain

___ ___ Being over-concerned about body weight and shape

8. Check any of the following that apply:

___ ___ I tend to do things on impulse which end up being damaging to me or others

___ ___ I have mood swings (depression, irritability, anger) lasting up to several hours

___ ___ I have tried to commit suicide

___ ___ I have made cuts, burns or other injuries to myself without wanting to kill myself

___ ___ My relationships always seem to work out wrong

___ ___ My mood often shifts from being either overconfident to having low self esteem

___ ___ I have a hard time sympathizing with other's pain

___ ___ I often feel others do not understand me

___ ___ I tend to get very hurt or angry when I am criticized or rejected by someone

___ ___ I tend to need a lot of reassurance or approval from others

___ ___ I am very concerned about my appearance

___ ___ Others often expect too much of me

9. Any of the following at any time:

___ ___ Hearing voices that sound real even though they are not actually there

___ ___ Vivid voices in my head that do not seem like my ideas

___ ___ Feeling that others might be putting thoughts in my head

___ ___ Feeling others might be able to read my thoughts

___ ___ Others feel I am too suspicious or paranoid

___ ___ Feeling others might be talking about me

Recent Past

10. Any of the following problems relating to a past severe trauma or stress:

___ ___ I have had an experience that was so traumatic that nearly anyone would have been seriously stressed by it

___ ___ History of relatives hurting me physically or touching me in sexual areas

___ ___ History of unwanted sexual contact

___ ___ I have memories or dreams of a stressful event that I have trouble putting out of my head

___ ___ I sometimes have flashbacks of past events; or I act or feel as though I am re-living a stressful event from the past

___ ___ I try to avoid situations or people that remind me of a stressful event in the past

11. Any of the following obsessions or compulsions:

___ ___ Excessive doubting; or repeated, forced unreasonable thoughts, images, or sounds that I cannot get out of my mind

___ ___ Urges to check things, wash things, or count repeatedly

___ ___ Excessive concern about coming into contact with germs or dirt

___ ___ Excessive concern with right/wrong or morality

___ ___ Excessive need for things to be exact or symmetrical

***Thank you!***