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Please fill out this form as completely as possible. This will make it unnecessary to ask you routine questions and will save time for more important discussions. All material is confidential and will not be released without your written request.

Today's date:

Name:		Birthdate:	Age
Address:		City:	Zip
Telephone: Home:	Work:	Other:	
Best time to Call:	Best time to Call:	Best time to Call:	
Occupation:		How long:	How long in present job:
Employer:		Address:	

Health Insurance Carrier:

Birthplace:	Religion:	Military Service: Branch & Dates
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How long have you lived in this area?	Last school grade completed:
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Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married / Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other	How long in present status?
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If you have been married more than once, please list the dates of marriages and whether each marriage ended by divorce, death or annulment: First: _____ to _____ Terminated by: Second: _____ to _____ Terminated by:	Number of children, if any, and their names and ages. Please indicate those who live with you.
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PLEASE LIST THE NAME OF THE PERSON OR AGENCY WHO REFERRED YOU:

CONCERNS:

1. What is the major reason you are seeking help at this time?

2. How long have these things been bothering you? Did they start gradually or suddenly?

3. What do YOU think is causing the problem?

4. What have you tried to do so far? How has that worked?

5. What objective do you have for yourself as a result of being in therapy?

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Have you been in therapy before? If so, when and with whom?

DATE	THERAPIST	LOCATION	LENGTH OF TREATMENT	TYPE OF TREATMENT	RESULTS
1.					
2.					
3.					

Check all items below that apply to your present condition:

- | | | |
|--|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unable to work well |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Can't get interested |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Financial problems | <input type="checkbox"/> Drink excessively |
| <input type="checkbox"/> Bowel trouble | <input type="checkbox"/> Depressed | <input type="checkbox"/> Excessive use of drugs |
| <input type="checkbox"/> Feel tense | <input type="checkbox"/> Panicky feelings | <input type="checkbox"/> Unable to have a good time |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Tremors or tics | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Unusual thoughts | <input type="checkbox"/> Always worried | <input type="checkbox"/> Can't make friends |
| <input type="checkbox"/> Strange experiences | <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Can't keep friends |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Feel worthless | <input type="checkbox"/> Feel apart from people |
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Can't make decisions | <input type="checkbox"/> Fear things I shouldn't |
| <input type="checkbox"/> Can't go to sleep | <input type="checkbox"/> Thoughts of suicide | <input type="checkbox"/> Conflict within family |
| <input type="checkbox"/> Can't stay asleep | <input type="checkbox"/> Ready to explode | <input type="checkbox"/> Fear I will lose self-control |
| <input type="checkbox"/> Other: | | |

What medications have you used during the last year?

Frequency and Amount?

Do you drink alcohol, smoke cigarettes or marijuana, or use other mood altering drugs? Any present / past problems?

Frequency and Amount?

What serious medical problems, surgery, or accidents have happened to you? When?

Have you had any legal difficulties?

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Identification of Concerns: Please indicate both your own concerns and your partner's.

Female Concerns:	Male Concerns:
<input type="checkbox"/> Low level or lack of interest in sex <input type="checkbox"/> Non-arousal, no lubrication <input type="checkbox"/> Lack of orgasm with partner <input type="checkbox"/> Lack of orgasm alone <input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Difficulty with entry in intercourse <input type="checkbox"/> Difference in sex drive in relationship to partner <input type="checkbox"/> Relationship or marital difficulties <input type="checkbox"/> Other, please specify: _____ _____	<input type="checkbox"/> Low level or lack of interest in sex <input type="checkbox"/> Rapid or premature ejaculation <input type="checkbox"/> Unable to have an erection <input type="checkbox"/> Unable to maintain an erection <input type="checkbox"/> Only able to have a partial erection <input type="checkbox"/> Unable to ejaculate during intercourse <input type="checkbox"/> Difference in sex drive in relationship to partner <input type="checkbox"/> Relationship or marital difficulties <input type="checkbox"/> Other, please specify: _____ _____

How long have you had this problem? Under what circumstances is this a problem for you?

Are there occasions when it is *not* a problem?

What do you think is causing the problem?

Are there any marital or relationship difficulties? Yes No If yes, explain:

When did these difficulties start?

If not married, do you have a regular sexual partner? Yes No

If no, do you find it hard to meet partners? Please explain:

Comments:
