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Initial Meeting Information

Please fill out this questionnaire in as much detail as you feel comfortable. There may be things you do not know or cannot remember. That is fine. If you need to use the back or additional paper in answering a question, go right ahead. This is NOT a test. It is an effort to save you time in the initial stage of therapy by getting as much history as possible early on. Only answer what you are ready to answer. If you are experiencing a difficulty, we are bound to find that out together sooner or later. Thanks!

Date: _____

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Fax Number (if applicable): _____

Place of Employment/School: _____

No. Hours per Week: _____

Date of Birth: _____ Age: _____

Marital Status: _____ No. Previous Marriages: _____

Name of Spouse: _____

Spouse's Employer: _____

Children (names and ages): _____

Physician: _____ Psychiatrist: _____

Medication(s): _____

Referred by: _____

Notify in Case of Emergency: _____

Relationship: _____

Daytime phone: _____

Insurance Coverage: _____ yes _____ no Company: _____

Policy Number: _____ Social Security Number _____

Background History

Have you ever received psychological treatment before? _____ yes _____ no

If yes, where? _____ Student Health/Counseling Center

_____ Mental Health Clinic

_____ Private Therapist

_____ In-Patient Hospitalization

_____ Other (please specify) _____

Do you have a Judicial Record? _____yes _____no

If yes, what were the charges/conviction and sentencing? _____

Marital Status of Your Parents _____Married _____Separated _____Divorced

_____Father Deceased _____Mother Deceased _____Father Remarried _____Mother Remarried

Father's Occupation _____ Mother's Occupation _____

Mention anything significant about your relationship with your parents: _____

Education of Father:

_____Did not finish high school

_____High school graduate

_____Did not finish college

_____Graduate degree

Education of Mother:

_____Did not finish high school

_____High school graduate

_____Did not finish college

_____Graduate degree

Number of Brothers: _____

Older: _____

Younger: _____

Half: _____

Number of Sisters: _____

Older: _____

Younger: _____

Half: _____

Your overall birth order: _____

Mention anything significant about your relationship with your siblings: _____

Is there anyone else that played a significant role in your early family life (grandparents, aunts, uncles, family friends...)? If so, please elaborate: _____

What form(s) of discipline was used in your family? _____

Who enforced the discipline used in your family? _____

How was your living environment? _____

What did you like most about your family? _____

What did you dislike most about your family? _____

Is there anything else you feel is important that has not been covered so far? _____

Do you consider yourself as having a problem with drugs or alcohol? _____yes _____no

Does anyone else consider your use of alcohol or drugs problematic? _____yes _____no

Has anyone in your family ever experienced substance abuse problems? _____yes _____no

Please mark the following: Never Stopped Less than 3 More than 3
Used Using Times/Week Times/Week

Your use of alcohol _____ _____ _____ _____

Your use of marijuana _____ _____ _____ _____

Your use of cocaine _____ _____ _____ _____

Your use of other drugs _____ _____ _____ _____

(i.e. amphetamines, tranquilizers,
hallucinogens)

Have you ever had an unwanted sexual experience (e.g. fondling, intercourse, rape, sexual harassment, etc.)? _____yes _____no If yes, check all that apply:

_____family member _____date or acquaintance

_____friend _____stranger

_____other (please specify)

Have you ever experienced difficulty with an eating disorder? _____yes _____no

If yes, check all that apply:

_____uncontrollable eating _____laxative use

_____rigid dieting _____other weight concerns

_____self-induced vomiting _____repeated fasting

Do you have any feelings (emotions) that you wish you could change? Please describe:

Do you have any behaviors that you wish you could change? Please describe:

Please name any significant changes in your life within the last six months:

What kind of support system do you have? _____

Describe your living environment today? _____

What are your goals for counseling? _____

Emotional and Social Inventory

Circle the number that best fits your experience:

1 **2** **3** **4** **5**
None A little Some Much Very much

Social Life and Relationship Skills

Too little social life	1	2	3	4	5
Too much social life	1	2	3	4	5
Difficulty saying "no" to others	1	2	3	4	5
Difficulty meeting people	1	2	3	4	5
Have hard time with close relationships	1	2	3	4	5
Concerned about being racially harassed	1	2	3	4	5
Concerned about my sexual behavior	1	2	3	4	5
Difficulty communicating	1	2	3	4	5
Inability to make or keep friends	1	2	3	4	5
Hurting people's feelings	1	2	3	4	5
Feel like I don't fit in anywhere	1	2	3	4	5
Am considering ending a close relationship	1	2	3	4	5
Concerned about being sexually harassed	1	2	3	4	5
Am sexually inappropriate with others	1	2	3	4	5
Afraid of losing someone I love	1	2	3	4	5
Concerned about someone else's sexual behavior	1	2	3	4	5
Interpersonal conflicts	1	2	3	4	5
Worry about what others think of me	1	2	3	4	5
Overly concerned about personal appearance	1	2	3	4	5
Unable to control my anger	1	2	3	4	5

Physical Health Issues

Feeling stressed	1	2	3	4	5
Nightmares/Restless sleep	1	2	3	4	5
Appetite Loss	1	2	3	4	5
Frequent headaches	1	2	3	4	5
Chronic or frequent illness	1	2	3	4	5
Weight concerns	1	2	3	4	5
Alcohol/Drug abuse	1	2	3	4	5
Lack of exercise	1	2	3	4	5
Too much energy	1	2	3	4	5
Under-eating	1	2	3	4	5
Overeating	1	2	3	4	5
Binging and purging	1	2	3	4	5
Concerns about sexually transmitted diseases	1	2	3	4	5
Concerns about Pregnancy	1	2	3	4	5

Emotional Health

Feeling sad often and for long periods	1	2	3	4	5
Feeling irritable	1	2	3	4	5
Angry outburst or prolonged anger	1	2	3	4	5
Feeling anxious	1	2	3	4	5
Extreme mood swings	1	2	3	4	5
Crying easily and often	1	2	3	4	5
Feeling depressed for long periods	1	2	3	4	5
Trust issues (too little, too much)	1	2	3	4	5
Suicidal thoughts	1	2	3	4	5
Have attempted suicide	1	2	3	4	5

Family Issues

Being criticized by my parents	1	2	3	4	5
Parent expectations of me too high	1	2	3	4	5
Parent's divorce/separation problematic	1	2	3	4	5
Concerned about past behavior of relatives, friends, or acquaintances	1	2	3	4	5
Sexual inappropriateness by family member(s)	1	2	3	4	5
My parents try to control me	1	2	3	4	5
Acute or chronic illness in family	1	2	3	4	5
Bothered by events of the past	1	2	3	4	5
Family non-supportive of my life choices	1	2	3	4	5
Concern about current family issues	1	2	3	4	5
Need parenting skills	1	2	3	4	5
Afraid of intimacy	1	2	3	4	5
Sexual problems in relationship	1	2	3	4	5

Thank you for your effort in filling out this questionnaire. It will save us valuable time in the counseling room. Feel free to address any or all of these issues with me as you feel comfortable. If there is anything I failed to ask but that you feel is important, please let me know here, in writing, or in the course of a session. I look forward to getting to know you and assisting you in any way that I can. Your questions and concerns are always welcome!

Sincerely,

Miriam Lieberman, MA, LPCS