



# PRE 1<sup>ST</sup> SESSION: INITIAL DIAGNOSTIC INTERVIEW

Pearl ■ Ridgeland ■ Clinton ■ Laurel ■ Southwest

Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Gender M or F

Please briefly describe why you are here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you had to describe your major symptoms for which you are seeking therapy, they would be:

- Depression
- Anxiety
- General Sadness
- Mood Swings
- Obsessive Worries
- Panic Anxiety
- Times of Confusion
- Loss of Memory
- Drug Abuse
- Inattention/Hyperactivity
- Behavior Problems
- Relationships or Family Issues
- Other \_\_\_\_\_

Please check the major stressor(s) that preceded or accompanied your symptoms:

- Marital Issues
- Parent/Child Issues
- Job Issues
- Health Issues
- Trauma
- Increased Obligations/Responsibilities
- Significant Change
- Financial Issues
- Issues of the Past (guilt, abuse, family of origin)
- Other \_\_\_\_\_
- Difficult to identify

My symptoms began \_\_\_\_\_ (  weeks or  months) ago and have been  increasing  decreasing  no change

My three biggest worries in life at the present time are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please describe your goals for therapy:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_



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**Please check all of the following that you have experienced and how often:**

Some Wkly Daily

- Increased Crying
- Sad Mood
- Lack of Motivation
- Poor Concentration
- Change in Sleep Pattern
- Appetite Changes
- Weight Changes
- Lack of Interest
- Decreased Self Esteem
- Hopeless/ Helpless Feeling
- Being Withdrawn
  
- Nightmares
- Rapid Heartbeat
- Increased Sweating
- Shortness of Breath
- General Anxiety
- Chest Discomfort
- Feeling Dizzy
- Chills or hot flashes
- Outburst of Anger
- Restlessness, keyed up, decreased concentration, irritability, muscle tension, decreased sleep
- Startled Response
  
- Feeling "High" with racing thoughts, increased speech, decreased sleep and increased activity or energy level
- Hypervigilance- excessive attention and focus on all internal and external stimuli
- Excessive behaviors such as shopping, gambling etc. Please list any others \_\_\_\_\_
  
- Inattention
- Hyperactivity
- Impulsiveness
  
- Fear of going crazy
- Obsessions/Compulsions- constant checking, washing, or counting type behaviors; unrelenting worries
- Hallucinations (hearing voices/music that no one else hears)
  
- Avoidance of anything associated with a trauma you experienced
- Post-Traumatic Stress experiences Please List \_\_\_\_\_
- Fear or anxiety of places or inescapable situation
- Social Phobia- persistent fear of social or performance situations where embarrassment may occur
- Specific Phobia-persistent fear of certain objects or situations Please list \_\_\_\_\_
- Isolating self from all contact with others
- Amnesia
- Running Away
- Truancy
- Memory impairment with trouble organizing and sequencing
- Undue health worries with no adequate explanation
- Agitated- irritable (easily annoyed and provoked to anger)
- Suspicious
- Delusions/Paranoia



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**Please select any of the following that you have EVER experienced:**

- Behavioral Problems
- Self Mutilation (cutting etc.) (If so, when was last occurrence)
- Eating Issues (Under or Overeating, Binging and Purging)
- Sexual Issues (addiction, performance anxiety, pornography)
- Legal Issues
- Severe Trauma
- Suicidal Thoughts    If yes, when did you last experience such thoughts? \_\_\_\_\_

## Family History

### Family of Origin

Describe Relationship with Father:

Describe Relationship with Mother:

Describe Relationship with siblings: (how many, where you are in birth order, your "role")

In general would you describe your childhood and family of origin as

- |   |   |
|---|---|
| <input type="radio"/> Pleasant                                    | <input type="radio"/> I have very little memory of my childhood |
| <input type="radio"/> Great                                       | <input type="radio"/> I was mostly withdrawn from my family     |
| <input type="radio"/> Normal amount of fussing but generally good | <input type="radio"/> Dysfunctional                             |
| <input type="radio"/> Abusive                                     |   |

### Current Family

Are you married? Y/ N    If yes, how many years? \_\_\_\_\_    Are you divorced? Y /N    How many years? \_\_\_\_\_

I presently live \_\_\_\_\_ with spouse    \_\_\_\_\_ alone    \_\_\_\_\_ with parents    \_\_\_\_\_ other \_\_\_\_\_

My sexual orientation is \_\_\_\_\_ heterosexual    \_\_\_\_\_ homosexual    \_\_\_\_\_ other

My current support system (including friends and family) is:

\_\_\_\_\_ Good    \_\_\_\_\_ Fair    \_\_\_\_\_ Poor

Please describe any current stress in your marriage/family:

Do you have children ? Y or N    If yes, how many? \_\_\_\_\_    Have you ever had an abortion? \_\_\_\_\_

Have you ever had a miscarriage? \_\_\_\_\_    Do you suffer from infertility? Y or N or Do not know



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### Drug/Alcohol History

Do you smoke cigarettes? Y or N

Do you have a desire to stop or reduce smoking? Y or N

Do you currently use drugs or alcohol? Y or N

If so, do you feel pressured by others to reduce the use of drugs or alcohol? Y or N

Do you often feel a sense of guilt and desire to reduce the use of drugs or alcohol? Y or N

If you use alcohol, please describe how often and for how many years you have used it

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If you have EVER used illegal drugs, please list what drugs you have used, how often and for how many years:

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### Medical History

Please list any *psychiatric* medications you are currently taking

Medication	Date Began	Side Effects
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1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Have you ever been diagnosed with a psychiatric or mental disorder? Y or N

If yes, please describe diagnosis \_\_\_\_\_

Have you been to counseling before? Y or N

Have you ever been hospitalized for a psychiatric disorder?

Please describe any current medical conditions you may have: (diabetes, asthma, etc.)

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Do you suffer from chronic pain? Y or N

If yes, please describe:

Are you taking any other (non-psychiatric) medications? Y or N



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### Religious Beliefs

Do you consider yourself religious/spiritual? Y/N/Somewhat

If so, what denomination/religion do you practice? \_\_\_\_\_

Is this the same as your family of origin? Y/N

Do you attend church \_\_\_ never \_\_\_ rarely \_\_\_ occasionally \_\_\_ once a month \_\_\_ nearly every week or more

### School/Career

What level of school did you complete?

\_\_\_ Middle School \_\_\_\_\_ Graduate or Professional Degree

\_\_\_ High School \_\_\_\_\_ GED

\_\_\_ College

\_\_\_ Currently in School or College (list grade or level \_\_\_\_\_)

Where are you currently employed? \_\_\_\_\_

Are you satisfied in your job? Y or N or Somewhat

Please describe any issues you may be having with your job/career or school: