JANE Z. WOODROW, PH.D.
CLINICAL PSYCHOLOGIST
507 Richland Ave., Ste. 203A
Athens, Ohio 45701-3700
740-592-5689(ofc)/740-593-7166

PERSONAL BACKGROUND

Date _____

Name _____ Sex ___ Birthdate _____ Age _____

Address _____ Zip _____ Phone _____

The information you give below is for professional use only, and will be held as confidential.

Who referred you or suggested you come here? _____

_____

Describe in your own words the nature of your main problems. _____

_____

_____

Expectations Regarding Therapy

In a few words, what do you think seeing a psychologist is all about? _____

_____

What do you think would be most helpful to you? _____

_____

How long do you think your therapy should last? _____

_____

Underline any of the following that applied to you or your family during your childhood/adolescence:

Happy Childhood	School Problems	Medical Problems
Unhappy Childhood	Family Problems	Alcohol Problems
Emotional/Behavioral Problems	Strong Religious Convictions	Physical Abuse
Legal Trouble	Suicide/Suicide Attempts	Drug Abuse
Others: _____	_____	_____

Problem or Symptoms List

(Check those that apply. Circle the 5 most troubling to you)

Difficulty falling or staying asleep
Eating problems (eg. overeating, vomiting, poor appetite)
Trouble with digestion or elimination
Timid and shy
Financial problems (eg. overspending, debt unemployed, gambling)
Lack of friends
Conflict with friends
Conflict with family
Worrying excessively
Difficulty relaxing
Getting excited too easily
Religious concerns
Difficulty concentrating
Doubting wisdom of my decisions
Allergies
Feeling like I don't belong
Easily discouraged
Fearful of loss of people
Forgetfulness
Weaknesses in reading, spelling, writing or math
Believe I am unattractive
Awkward in dealing with people
Easily get my feelings hurt
Unhappy too much of the time
Nervous habits
Trouble organizing
Strong fears of certain places, things or people
Frequent illnesses
Work difficulties
Lack of privacy
Too envious or jealous
Too stubborn
Speaking or acting without thinking
Losing my temper
Acting childish or immature at times
Others expecting too much of me
Frequent headaches
Can't make up my mind about things
Lack of self-confidence
On edge much of the time
Thoughts about hurting others
Have hurt others physically
In stressful situation
Family troubles
Sometimes lying without meaning to
Unable to break a bad habit
Difficulty coping with rules and regulations
Hurting others' feelings
Too self-centered
Sometimes bothered by fears of insanity
Thoughts of suicide
Troubled or guilty conscience
Giving in to temptations
Memory problems
Sexual inhibitions
Concerns regarding sexual orientation
Have been in trouble for sexual behavior
Other sexual concerns
Tics or involuntary sounds or movements
Self-harming behavior (eg. cutting myself)
Sometimes don't know where I am or where I've been
Others complain about my behavior or that I upset them
Crying for long periods or without knowing why
Periods of severe panic
Trouble trusting others
Moody
Abuse of alcohol or drugs
Bad memories sometimes return and interfere with what I'm doing
Unable to work like I used to
Losing interest in things
Feel hopeless
Trembling
Thinking about same thing over and over
Doing same thing over and over (eg. checking if door is locked more than once)
Bad dreams or nightmare
Shoplifing
Fear of making mistakes
Feeling that no one understands me
Feeling life gave me a "raw deal"
Other concerns (What are they?) _____
_____

PRESENTING PROBLEMS

Symptoms:

___ Anger
___ Anxiety
___ Compulsive behaviors
___ Confusion
___ Depression
___ Excessive Use of Alcohol or drugs
___ Headaches
___ Hopelessness
___ Impulses to hurt self or others
___ Disorientation (moments of not knowing where you are or who you are)
___ Visual or auditory hallucinations (seeing or hearing things)
___ Irritability
___ Lack of energy
___ Loss of interest
___ Memory loss
___ Mood swings
___ Nausea/vomiting
___ Self-critical
___ Seizures
___ Shortness of breath
___ Sleep difficulties
___ Suicidal thoughts
___ Suspiciousness
___ Thought disorder
___ Obsessive preoccupations or repeated thoughts
___ Weight gain or loss
___ Medical problems:_____

Couple relationship
___ Tension
___ Arguments
___ Emotional distance
___ Sexual difficulties
___ Communication problems
___ Alcohol or other addiction problems
___ Stresses from health problems
___ No couple relationship, which is ___, is not ___ a problem

With children Names and Ages:_____
_____
___ Tension
___ Angry interchanges
___ Children exhibiting emotional problems
___ Children exhibiting behavioral problems
___ Problems in relationships between siblings
___ Health problems
___ No children, which is ___, is not ___ a problem.

Extended family
___ Recent losses
___ On-going difficult interactions with _____.

Work-related (or school-related)
___ Upsetting interactions
___ Financial insecurity

Community-related
___ Insufficient friendships
___ Tensions in friendship relationships
___ Over-extended in friendship or community role
___ Other _____

PRESENT FAMILY (include yourself and all family members)

NAME	RELATIONSHIP TO YOU	AGE	SEX	MARITAL STATUS	AT HOME? YES OR NO	EDUCATION	OCCUPAT

	NAME	RELATIONSHIP TO YOU
Who else lives with you?		
Who else is important to you now?		

Who was in your family when you were growing up?

NAME	RELATIONSHIP TO YOU	AGE	SEX	EDUCATION	OCCUPATION	WHERE ARE THEY NOW?

Have you ever been married before? Yes_____ No_____

NAME OF SPOUSE	DATE MARRIAGE BEGAN	DATE MARRIAGE ENDED	DIVORCE YES NO	NAMES OF CHILDREN FROM THIS MARRIAGE

Medical History

1. List any long physical illnesses, accidents, operations, etc. (include epilepsy, brain damage, etc.) Also any current medical concerns.

DATE	PROBLEM	WHAT TREATMENT	DOCTOR'S NAME

2. List previous treatment for emotional, mental or substance abuse problems

DATE	PROBLEM	WHAT TREATMENT	DOCTOR'S NAME

3. List current medicines

NAME	HOW STRONG	HOW OFTEN PER DAY	WHAT FOR

4. List all allergies (including to drugs) _____

_____

5. What is your current state of health? (Circle one) Excellent / Good / Fair / Poor

6. What I use or did use:

	Age at First Use	Last Used	How Many Used Now Per Day/Per Week
Tobacco			
Caffeine			
Alcohol			
Marijuana			
Amphetamines			
Cocaine			
Heroin			
LSD/Hallucinogens			
Prescription Drugs (List these Used in Excess of Prescrption)			

School History

1. What is the highest grade you completed in school or highest degree? _____
2. How old were you when you left school? _____ Why did you leave school? _____
3. What diplomas, certificates or special training have you received? _____ _____
4. How did you get along in school? _____ _____
5. While in school, what activities were you involved in? _____ _____
6. Did you have close friendships? (Circle) one / a few / many / none

Job History

1. What is your present job? (including homemaker) _____
2. Are you satisfied with your present job? _____
3. How long have you had it? _____
4. Why did you leave your last previous job? _____ _____
5. What other kinds of jobs have you had? _____ _____
6. During the last 5 years, approximately how much time have you been unemployed? _____
7. If you could have any job you wanted, what kind of job would you choose? Why? _____ _____

Additional Information

1. What hobbies or interests do you have? _____
2. Do you consider yourself to be religious? ____What is your religion, religious heritage or church affiliation? _____
3. What troubles have you had with the law? _____ _____