

JTS Counseling Center

Welcome to the Counseling Center. In order to better understand your concerns, we have prepared this brief form. Answering the form is optional. All information is kept in strict confidence.

PLEASE FILL OUT THE FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT. TO SAFEGUARD AND ENSURE YOUR CONFIDENTIALITY, PLEASE PUT YOUR NAME ON THE FORM ONCE YOU ARE WITHIN THE COUNSELING CENTER.

Please check ALL of the reasons you are seeking counseling or psychotherapy

- | | |
|--|--|
| 1. ___ Anxiety | 11. ___ Family problems |
| 2. ___ Bereavement | 12. ___ Planning the future |
| 3. ___ Confusion about self-image, goals, etc. | 13. ___ Concerns about my appearance |
| 4. ___ Confusion about major or career | 14. ___ Issues surrounding food |
| 5. ___ Decreased performance at work,
home, or school | 15. ___ Concerns about sexual abuse |
| 6. ___ Depression | 16. ___ Concerns about physical abuse |
| 7. ___ Health status of myself | 17. ___ Aftermath of a trauma, please specify: |
| 8. ___ Health status of someone I care about | 18. ___ Social isolation or loneliness |
| 9. ___ Memory problems | 19. ___ Other, please specify:
_____ |
| 10. ___ Relationship problems | |

Regarding the following traits, abilities, and emotions, please check whether you are satisfied or dissatisfied.

Trait, Ability, or Emotion	Satisfied	Dissatisfied
Assertiveness	S	D
Communicating with friends	S	D
Communicating with potential partners	S	D
Stress management	S	D
Time management	S	D
Sleeping well/getting a good night's rest	S	D
Coping with my own anger	S	D
Coping with others' anger	S	D
Feeling rejected	S	D
Feeling shy	S	D
Finding and maintaining friends	S	D
Getting my work done	S	D
Feelings of positive self-regard and self-esteem	S	D

Please share with us your feelings about the support you may be getting from friends and family.

	All of the time	Most of the time	A lot of the time	Some of the time	A little of the time	None of the Time
I get support from my family	1	2	3	4	5	6
I get support from my friends	1	2	3	4	5	6
I get support from my partner (if applicable)	1	2	3	4	5	6

Below is a list of problems people sometimes have. Please read each one carefully, and circle the number that best describes how much that problem has distressed or bothered you during the past month. Circle only one number for each problem and do not skip any items.

HOW OFTEN DO YOU EXPERIENCE:

	All of the time	Most of the time	A lot of the time	Some of the time	A little of the time	None of the time
Nervousness or shakiness inside	1	2	3	4	5	6
Faintness or dizziness	1	2	3	4	5	6
Feeling afraid in open spaces or on the streets	1	2	3	4	5	6
Suddenly scared for no reason	1	2	3	4	5	6
Feeling fearful	1	2	3	4	5	6
Nausea or upset stomach	1	2	3	4	5	6
Having to check and double check what you do	1	2	3	4	5	6
Difficulty making decisions	1	2	3	4	5	6
Feeling afraid to travel on buses or trains	1	2	3	4	5	6
Needing to avoid certain things	1	2	3	4	5	6
Your mind going blank	1	2	3	4	5	6
Feeling tense or keyed up	1	2	3	4	5	6
Feeling uneasy in crowds such as shopping malls	1	2	3	4	5	6
Spells of terror or panic	1	2	3	4	5	6
Feeling so restless you can't sit still	1	2	3	4	5	6
Feeling unsafe or in danger	1	2	3	4	5	6
Feeling that people are unfriendly or dislike you	1	2	3	4	5	6
Feeling inferior to others	1	2	3	4	5	6
Worrying about being talked about by others	1	2	3	4	5	6
Tempers outbursts that you could not control	1	2	3	4	5	6
Feeling angry	1	2	3	4	5	6
Feeling very self-conscious with others	1	2	3	4	5	6
Never feeling close to another person	1	2	3	4	5	6
Getting into frequent arguments	1	2	3	4	5	6
Feeling nervous when you are left alone	1	2	3	4	5	6
Others not giving you the proper credit for your achievements	1	2	3	4	5	6
Feeling that people will take advantage of you if you let them	1	2	3	4	5	6
Feeling lonely	1	2	3	4	5	6
Feeling confused about your identity	1	2	3	4	5	6
Feeling uncomfortable or confused around others	1	2	3	4	5	6
Feeling unhappy with your body	1	2	3	4	5	6
Exercise more than an hour a day	1	2	3	4	5	6
Concerned about being overweight	1	2	3	4	5	6
Bouts of uncontrollable eating	1	2	3	4	5	6
Frequent use of laxatives and/or vomiting	1	2	3	4	5	6

As mentioned above, answering any of these questions is optional.

Please tell us of any losses you have experienced:

Have you lost any significant family or friends? ___ Yes ___ No

If yes, please share with us who you have lost and when:

Relationship:

Date:

1. _____
2. _____
3. _____

Were you parents ever separated or divorced? ___ Yes ___ No

If yes, how old were you at the time of the separation/divorce? _____

Please list the age and occupation of your parents:

Father: Age _____ Occupation _____

Mother: Age _____ Occupation _____

Please list your siblings and their ages:

Please list the different places you have lived in and your approximate age when you moved (i.e. different cities, states, or countries):

Place:

Age:

1. _____
2. _____
3. _____

	None or a little of the time	Some of the time	Good part of the time	Most or all the time
I feel downhearted, blue, and sad	1	2	3	4
Morning is when I feel best	1	2	3	4
I have crying spells or feel like it	1	2	3	4
My appetite has increased/decreased	1	2	3	4
I have trouble sleeping through the night	1	2	3	4
I enjoy looking at, talking to, and being with attractive women/men	1	2	3	4
I notice that I am losing weight	1	2	3	4
My mind is as clear as it used to be	1	2	3	4
My heart beats faster than usual	1	2	3	4
I feel that I am useful and needed	1	2	3	4
I have trouble with constipation	1	2	3	4
I find it easy to do the things I used to do	1	2	3	4
I am restless and can't keep still	1	2	3	4
I feel hopeful about the future	1	2	3	4
I am more irritable than usual	1	2	3	4
I find it easy to make decisions	1	2	3	4
I get tired for no reason	1	2	3	4
My life is pretty full	1	2	3	4
I feel others would be better off if I were dead	1	2	3	4
I still enjoy the things I used to	1	2	3	4
Uncontrollable mood swings	1	2	3	4
Feelings of guilt	1	2	3	4
Thoughts of death or dying	1	2	3	4
Trouble concentrating	1	2	3	4