CYPRESS
COUNSELING CENTER, P.C.

PSYCHOTHERAPY INVENTORY

*The information in this inventory is for the use of your psychotherapist in the evaluation process. All material contained in this questionnaire will remain strictly **confidential** and will not be shared without your knowledge and permission.*

Name: ______________________________ DOB: ______________ Age: ________

Preferred name: __________________________ Preferred pronouns: ________________

Racial/ethnic/cultural identity: ______________ Gender identity: ________ Sexual orientation: ________

Address: ____________________________ City/State/Zip: ____________________

Please describe the events that led to the decision to seek therapy at this time. ____________________

____

In your opinion, what has caused these concerns? ____________________________________

________________________________ When did these concerns begin? ____________

Home and Family:

Please describe your relational status (include date(s) of cohabitation, marriage if applicable) and current satisfaction in that relationship:

____

Please describe each member of your household and your relationship with them (include names & ages):

____

____

If applicable, please describe your relationship with each child or stepchild living outside of your household (include names & ages):

____

____

Please describe any cultural, spiritual, or religious practices that are important to you or members of your household. If applicable, please include how you would like your therapist to honor or incorporate these values in therapy:

____

____

Physical and Psychological Health

Have you been in therapy before? If yes, please describe (include therapist name, agency, dates, type of therapy):

____

____ Was it helpful?:

____

Please list previous psychiatric hospitalizations (hospital, dates, reason for hospitalization): ____________________

____

Please describe any psychological concerns in your family and extended family (include diagnoses, medications, suicidal ideation/attempts, hospitalizations):

____

____

Please describe your history of traumatic experiences (including, but not limited to, verbal/physical/emotional/sexual abuse, neglect, divorce, loss of a loved one, witnessing violence) :

____

____

Date of your last physical with a physician: _________ Reason for appointment: ____________________________

Height: _______ Weight: _______ Please describe your physical activity/exercise: __________________________

Please describe your feelings about your body, weight, and physical activity? _______________________________

____

Please describe and date your history of major illnesses, hospitalizations, surgeries, or other physical health concerns:

____

____

List all medication(s) you are taking, include name, dose, frequency:_______________________________________

____

____ Are they helpful? ___________________

List your history of psychotropic medications, include adverse reactions & effectiveness: _____________________

____

Any issues with significant or sudden weight loss or gain? If yes, please describe: ____________________________

____

Challenges with eating and appetite (i.e. binging, overeating, anorexia, bulimia, etc.)? _________________________

____

Challenges with sleep (i.e. difficulty falling or staying asleep, nightmares/terrors, sleep walking, sleep apnea, etc.)?

____

____ Do you use sleep aids?_____________________

WOMEN ONLY

Age of onset of periods: _________ Please describe pain or changes in mood around your period: ____________

____

Have you ever been pregnant? ____________ Date(s) and your age(s) at pregnancy: _______________________

Was/were the pregnancy(ies) planned? _________ You and your partner's reaction:
____

Please describe complications during or following pregnancy, including changes in mood:____________________

____

Have you experienced an abortion, miscarrage, or stillbirth? If yes, please date and describe:__________________

____

Are you trying to conceive? _________________ Are you dealing with infertility? _________________________

If applicable, please describe your experiences with menopause: ____

Substance Use and Legal History

How often do you consume alcohol? _____________ How many drinks do you typically have? _________________

When did you last consume alcohol? _____________ How many drinks did you have? _________________________

When did you first consume alcohol? _____________ Describe this experience: ______________________________
Do you use other mood altering substances (e.g. marijuana, opiates, stimulants, hallucinogens)? If yes, please describe your relationship with each substance, frequency of use, and age at first use:

____

____

_________________________________ When is the last time you consumed each substance? __________________

Have you used mood altering substances in the past? If so, please describe your past relationship with each substance and the reason you no longer use:

____

_______________________________________ Are you involved in a recovery community?____________________

Please describe your legal history, include license suspension, arrests, jail time, legal or civil charges: ____________

____

Do any members of your household or family misuse substances? Is anyone experiencing legal difficulties? If yes, please explain its impact on you:

____

Childhood and Family History

Please describe positive aspects of your childhood: ____

____

Please describe difficult aspects of your childhood: ____

____

Please describe your parents/caregivers and your relationships with them: ___________________________________

____

____

Please describe your relationship(s) with step-parent(s) or influential adult(s) in your childhood: ________________

____

Please describe your parents' relationship with each other, include dates of marriage, separation, and divorce, and relationship with step-parent(s) if applicable:

____

Please describe your siblings/step-siblings and your relationship with them: ____________________________

____

Please describe your family members' physical and psychological health and its impact on you: ______________

____

Were you adopted? _____ If yes, please describe circumstances: ______________________________________

Did you or your mother experience complications surrounding your birth? If yes, please describe: _____________

____

Where were you born? _______________ Please describe major moves during your lifetime: __________________

____

Did you meet developmental milestones (e.g. talking, walking) on time? ______________________________

Academic and Occupational Background

Please describe elementary and middle school, include relationships with peers and teachers/coaches, academic strengths and difficulties, and extracurriculars:

____

____

Please describe high school, include relationships with peers and teachers/coaches, academic strengths and difficulties, extracurriculars, and after-school responsibilities:

____

____

Did you receive accommodations or attend special education programs? If yes, please describe: _______________

____

If applicable, please describe your experience in college and graduate school, include date and type of degree:

____

____

Are you a student or planning on attending school? If yes, please describe your experience or goals: _____________

____

Are you currently employed? If **yes**, please describe your current role and your satisfaction with it. If **no**, please describe your main life activity (i.e. caring for child/loved one, searching for employment, unable to work) and satisfaction with it:

____

____

If applicable, please describe your partner's employment or main life activity: _______________________________

____

<u>Social Relationships</u>

Please describe your relationships with friends, colleagues, roommates:____________________________________

____

Are you satisfied with your friendships and your ability to develop and maintain friendships? Do you feel isolated or lonely? Please describe:

____

Are you sexually active? If so, are you using safe-sex practices? Are you satisfied with your sexual relationship(s)?

____

<u>Areas of Interest and Strengths</u>

Please describe how you like to spend your free time and your areas of interest: ______________________________

____

What are your greatest strengths? What are you most proud of? ____

____

Please share any other information you would like your therapist to know about you: _________________________

____

Emergency Contact:

____

Name *Relationship to you* *Phone number*

Your Signature *Date*