**LIFE-STYLE QUESTIONAIRE INVENTORY**

# Directions

List below your siblings and there ages as you were growing up. Pick a particular age for yourself that seems especially memorable.

Age

1. Myself

2. Older sister

3. Older brother

4. Younger sister

5. Younger sister

You notice the descending order is numbered beginning with 1, (myself) and ending with 5, (youngest sister). The numbers will be used to rate brothers and sisters on a particular item.

Example:

# Helping around the house

most \_\_\_2\_\_\_\_ more \_\_\_3\_\_\_ average\_\_\_4\_\_ less\_\_1\_\_\_\_ least\_\_\_5\_\_\_

In this example the older sister is most helpful. You do not help as much, but you are more helpful than your younger sisters.

This is not a test. There are no ‘right’ or ‘wrong’ answers. Take as much time as you need; answer as fairly as you are able.

# Part I

Now make your own list according to directions given. Include yourself.

Age Age

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

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using the birth order number (1,2,3, etc.) rate each family member on the traits listed below. Fill this rating with your siblings as if you are twelve years old.

Intelligence most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Hardest worker most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Best grades in school most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Helping around the house most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Obedient most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Rebellious most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Trying to please most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Critical of others most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Considerate most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Selfish most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Having own way most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Sensitive –easily hurt most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Temper tantrum most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Highest aspiration most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Materialistic most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Desire to excel most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Good behavior most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Athletic most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Spoiled most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

Punished most \_\_\_\_ more \_\_\_\_ average\_\_\_\_ less\_\_\_\_ least\_\_\_\_

# Part II

Directions: Continue to use the numbers in answering the following questions.

Space is provided for brief comments.

1. Among your brothers and sisters, who is most different from you?

In what way?

2. Who is most like you?

In what way?

3. Which of you has the most friends?

4. Who is father’s favorite?

5. Who is your mother’s favorite?

6. Which two fight and argue the most?

7. Which two play together most?

8. What kind of person was your father?

9. What kind of person was your mother?

10. Who were you most like? In what ways?

# Part III

Give a brief description of yourself:

# Part IV

Try to remember your earliest recollections. Include as many details as you can as well as your reactions and feelings. Make sure that it is a recollection you remember and not information someone of your family has reported to you. Please provide three different recollections

Example: I was five years of age, and I remember throwing my older brother down to the floor. I felt strong, proud and powerful.

Please add as many details as you can remember for each example.

*INTAKE QUESTIONNAIRE – ADULT*

**ABOUT YOU** *Your response to the following questions will help your therapist better understand you and your situation in order to provide the best possible service. Please answer all questions as completely as possible.*

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Situation (who lives in your home with you): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Your Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Where were you born?\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_

Employer’s Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

**Race/Ethnicity:**

White/Caucasian  Hispanic or Latino

Asian  American Indian or Alaska Native  Black/African American  Native Hawaiian or Pacific Islander

**Sexual Orientation:**

Heterosexual  Bisexual  Gay/Lesbian  Transgender  Uncertain

**Disability:**

Do you have a disability?  Yes  No If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a disability, does the office accommodate your needs?  Yes  No

If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you feel that the therapist should be aware of any special treatment considerations due to gender, age, sexual orientation or cultural, religious, national, racial or ethnic identity, please explain below:

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

Who referred you to the Wellness Clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PLEASE LIST ANY SCHOOL AND COLLEGES YOU ATTENDED, ALONG WITH DIPLOMAS, DEGREES AND APPROXIMATE DATE OF AWARD***

**Name of School Diploma or Degree Year(s)**

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

**Military Service**:  NO  YES **If Yes, Length of Duty \_\_\_\_\_\_\_\_\_\_\_\_ Honorable Discharge**

NO  YES

**Spirituality:**

How Important Are Spiritual Matters To You?

Not At All  A Little  Very Important

Are you affiliated with any spiritual or religious group?  NO  YES Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to discuss spiritual matters with your counselor in relation to helping with your present issues? NO  YES  Maybe

# ABOUT YOUR SPOUSE OR SIGNIFICANT OTHER

# Name of your spouse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is your spouse employed?\_\_\_\_\_\_\_\_\_

If so, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What does she/he do?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns or questions about your spouse or marital status that we should be aware of, or that you would like to discuss?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please briefly note them here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ABOUT YOUR CHILDREN

Names and age of children: (include stepchildren living with you)

Name Age Date of Birth

# FAMILY HISTORY

***Please list your brothers and sisters and their ages.***

Name Age

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

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

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

What was your father’s occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your father living?\_\_\_\_\_\_ If not, approximate date of death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your mother’s occupation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your mother living?\_\_\_\_\_ If not, approximate date of death:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the quality or nature of your relationship with your parents and note any questions or concerns you might wish to raise regarding that relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

## LEGAL HISTORY

Please describe any involvement you have had with the legal system (arrests, convictions, probation, parole):

|  |
| --- |
|  |
|  |
|  |

**PRESENTING PROBLEM (current situation and history)**

1. What is the primary problem for which you are seeking help? (please circle)

a. Marriage or relationship g. Problems with children m. Grieving

b. Family problems h. Peer problems n. Abuse or trauma

c. Depression i. Eating disorder o. Sexual functioning

d. Mood swings j. Alcohol/drug use p. Anger

e. Behavior k. Physical problems q. Anxiety or worry

f. Self-confidence l. Work related r. Other (explain):

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

2. How long have you had this/these problem(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you received treatment for this problem or any other problem in the past?  Yes  No

### Previous Mental Health Treatment

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **YES/NO** | **When** | **Where** | **Outcome** |
| Counseling? | Yes  No |  |  |  |
| Psychiatric Treatment? | Yes  No |  |  |  |
| Past/Current  Diagnosis? | Yes  No |  |  |  |
| Self Injury? | Yes  No |  |  |  |
| Suicidal Thoughts? | Yes  No |  |  |  |
| Suicide Attempt? | Yes  No |  |  |  |
| Danger to Others? | Yes  No |  |  |  |

**MEDICAL HISTORY**

Name and address of family Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical examination\_\_\_\_\_\_\_\_\_\_\_\_\_

List any past or present illnesses, infirmities or disabilities of any consequence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list significant hospitalizations, operations, injuries (including broken bones): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Medications You Are Taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please rate the severity of any current or recent (within the past 6 months) symptoms or problems by assigning either a 1,2,3,4 or 5 from the following scale:***

1- Very mild 2-Somewhat mild 3-Moderate 4-Somewhat Severe 5-Severe

|  |  |
| --- | --- |
| \_\_\_\_\_\_a. anxiety, tension, nervousness  \_\_\_\_\_\_b. coldness or numbness in fingers  \_\_\_\_\_\_c. frequent or severe headaches  \_\_\_\_\_\_d. skin problems (i.e. rash, acne or dermatitis)  \_\_\_\_\_\_e. frequent upset stomach/ indigestion/ nausea  \_\_\_\_\_\_f. depression or crying spells  \_\_\_\_\_\_g. chronic pain (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  \_\_\_\_\_\_h. dizziness or fainting spells  \_\_\_\_\_\_i. diarrhea or constipation/ urinary problems  \_\_\_\_\_\_j. memory problems/ inability to concentrate  \_\_\_\_\_\_k. excessive alcohol, drug or medication use  \_\_\_\_\_\_l. excessive caffeine use (e.g. coffee, tea, chocolate, soda)  \_\_\_\_\_\_m. high blood pressure/ hypertension | \_\_\_\_\_\_n. muscle tension/ spasticity/ cramps  \_\_\_\_\_\_o. heart palpitations or pounding  \_\_\_\_\_\_p. frequent worrying/ preoccupation  \_\_\_\_\_\_q. stiffness, aching or burning sensation in joints  \_\_\_\_\_\_r. lack of energy/ frequent fatigue or sluggishness  \_\_\_\_\_\_s. lack of appetite  \_\_\_\_\_\_t. excessive appetite  \_\_\_\_\_\_u. shortness of breath/ rapid breathing  \_\_\_\_\_\_v. problems with falling asleep  \_\_\_\_\_\_w. frequent wakening/ early wakening  \_\_\_\_\_\_x. excessive energy/ hyperactivity  \_\_\_\_\_\_y. sexual functioning problems  \_\_\_\_\_\_z. irritability/ temper control problems  \_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**HISTORY OF TRAUMA**

Have you ever been molested or sexually abused?  Yes  No

Physically, verbally or emotionally…Have you faced any trauma in your life? If Yes, Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### GOALS

1. What are your strengths? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

2. What are your weaknesses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. Rate your current overall Wellness (1 = the lowest, 10 = your best) \_\_\_\_\_\_\_\_\_\_\_

4. What goals would you like to see reached as a result of therapy?

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

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5. What level of improved Wellness would you like to achieve? (scale of 1 – 10) \_\_\_\_\_\_\_\_\_\_\_\_

6. How will you know when these goals have been reached?

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

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|  | THERAPIST REVIEW | | | | | | |  |
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|  | Signature: |  | | |  | Date: |  |  |
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