NEW ENGLAND PASTORAL INSTITUTE, INC.

5 Summer Street
Lynnfield, MA 01940
603-890-6767

15 Ermer Road, Suite 215
Salem, NH 03079
603-890-6767
FAX 603-893-6767

20 West Park Street, Suite 214
Lebanon, NH 03766
603-448-2414

Adult Pre-Treatment Questionnaire

Please fill out as completely as you can and bring with you to your first therapy appointment. The information you provide is confidential and protected by law.

Name: _____ Date of Birth: _____
Address: _____
Phone Numbers: Home: _____ Work:_____ Cell: _____ email: _____

1. Sex: _ Male _ Female

2. Age: ___ Years

3. Partner/Marital Status:
__ Never Married
__ Living together
__ Married
__ Separated
__ Divorced
__ Widowed

4. Current Employment
__ Full-time
__ Part-time
__ Homemaker
__ Unemployed
__ Laid off
__ Student
__ Disabled
__ Retired

5. Education
__ Grade 8 or less
__ Some high school
__ High school graduate
__ Some college
__ College graduate
__ College beyond BS/BA

6. Children in the Family __ None

Name	Gender(circle)	Age (list)	Primarily living in your home?
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No
_____	M F	____	Yes No

7. Are you currently under a physician's care? (circle one) Yes No
If yes, name of physician and reason: _____
List any current medications and dosage: _____
_____
_____

8. Have you received prior counseling or related services? (circle one) Yes No
Name of therapist: _____ Where: _____
Length of treatment: _____mos./years How long ago? _____ mos./years ago
Problem(s) treated: _____
Outcome: (circle one):
1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

Name of therapist: _____ Where: _____
Length of treatment: _____mos./ years How long ago? _____ mos./years ago
Problem(s) treated: _____
Outcome: (circle one):
1 2 3 4 5 6 7 8 9 10
Much worse Stayed the same Much better

9. Please check any of the reasons listed below which led you to seek treatment, circling up to the 3 **most important**:

__ Depression or anxiety
__ Worry about drinking or drug use
__ Communication problems
__ Desire to improve sexual relations
__ Parent/child conflict
__ Sexual orientation questions
__ Problematic or too much anger
__ Social isolation or other social challenges
__ Trouble controlling impulses
__ Abuse (physical/sexual/emotional/verbal)
__ Trauma other than abuse (natural disaster, accident, crime witness, etc.)
__ Thinking of harming self or others
__ Learning/memory problems
__ Difficulty with loss or death
__ Want relationship to be better
__ Divorce counseling
__ Individual counseling
__ Pre-marital counseling
__ Family counseling
__ Couples counseling
__ Partner/family member wanted me to come
__ Other: _____

10. Regarding the **most important** reasons that bring you here, please rate the following:

Issue 1. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

Issue 2. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

Issue 3. _____

How often does issue happen?
__ Happens rarely
__ Happens 1-2 times a week
__ Happens 3-5 times a week
__ Happens daily
__ Happens several times a day

How does it affect your functioning?
__ I can do all the things I need and want to do
__ I struggle a bit but am able to do all I need and want to do
__ I can only do some of the things I need and want to do
__ I can barely do the things I need to do
__ I am unable to work or care for myself

How concerned are you?
__ Not concerned
__ A little concern
__ Moderately concerned
__ Very concerned
__ Paralyzed with concern

11. Who referred you to the New England Pastoral Institute? _____

12. What questions do you hope will be answered? _____
_____
_____
_____

13. Is there anything else you want the therapist to know before your first session? _____
_____
_____
_____

14. Person to contact in case of emergency: _____

Relationship: _____ Address: _____

Phone numbers: Home: _____ Work: _____ Cell: _____

15. Signature: _____ Date: _____