

Initial Counseling Questionnaire

Name:

Date:

27. I get depressed.	
28. I get anxious or often become highly emotional.	
29. I am often tense and have a hard time relaxing.	
30. My mind often races and I have difficulty being still.	
31. I have difficulty becoming sexually aroused or maintaining arousal.	
32. I cry at the drop of a hat.	
33. I have difficulty making decisions.	
34. I have difficulty concentrating or remembering things.	
35. I feel worse during the holidays or other family occasions.	

For office use only:

I am seeking Counseling for the following reasons:

I have seen a counselor before? Yes No If yes, was it within the last 5 years?
If yes, was it over 5 years ago?

Any other medical concerns:

Medications you are currently taking: