

DR. E. ANTHONY ALLEN
 Consultant Psychiatrist
Personal Information Questionnaire

Complete the easiest items first. This information will assist in your treatment. It will also help you to assess yourself and set your own goals for treatment and growth. Add information to a blank sheet as necessary.

Name: _____ Date: _____
 Current General Practitioner _____ Counsellor _____

FAMILY

Spouse: Name _____ D. O. B. _____ Age _____
 Occupation _____ Religion _____

Parents: Father _____ Age _____ Religion _____
 Occupation _____
 Deceased: yes / no Year (if yes): _____ Cause: _____
 Mother _____ Age _____ Religion _____
 Occupation _____
 Deceased: yes / no Year (if yes): _____ Cause _____

Rate your **father's relationship to his children** as a whole. Rate your **mother's relationship to her children** as a whole.

Not Good	Moderate	Good	Very Good	Not Good	Moderate	Good	Very Good

Parent's relationship with each other:

PAST -	Not Good	Moderate	Good	Very Good
PRESENT -	Not Good	Moderate	Good	Very Good

Comment on any difficulties. Include and indicate *past* and *present* problems that are significant.

Brothers and sisters:

	Name and Occupation	Sex and Age	Marital Status	Living Overseas?	Rate your relationship with that person			
					Not Good	Moderate	Good	Very Good
1.	_____	_____	_____	_____				
2.	_____	_____	_____	_____				
3.	_____	_____	_____	_____				
4.	_____	_____	_____	_____				
5.	_____	_____	_____	_____				
6.	_____	_____	_____	_____				

Rate your siblings' relationship to each other

Your position in family: _____ of _____ (e.g. 1st of 5)

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Comment on difficult relationships and problems. Include and indicate *past* and *present* problems that are significant.

Children :

	Name and Occupation	Sex and Age	Marital Status	Living Overseas?	Rate your relationship with that person			
					Not Good	Moderate	Good	Very Good
1.	_____	_____	_____	_____				
2.	_____	_____	_____	_____				
3.	_____	_____	_____	_____				
4.	_____	_____	_____	_____				
5.	_____	_____	_____	_____				
6.	_____	_____	_____	_____				
					Rate your childrens' relationship with each other			

Comment on difficult relationships and problems. Include and indicate *past* and *present* problems that are significant.

I Relationship with Father During Childhood

Check appropriate box: NONE LITTLE MODERATE GREAT

1.	How much did you talk with & confide in your father?				
2.	How much did you feel your father loved and accepted you?				
3.	How much affection and praise did your father give to you?				
4.	How much activities did your father engage in with you?				
5.	How much skill did your father show in providing for the family?				
6.	How much skill did your father show as a homemaker, if and when he had to?				

Comment on difficulties specified and others as necessary

II Relationship with Mother During Childhood

Check appropriate box: NONE LITTLE MODERATE GREAT

1.	How much did you talk with & confide in your mother?				
2.	How much did you feel your mother loved and accepted you?				
3.	How much affection and praise did your mother give to you?				
4.	How much activities did your mother engage in with you?				
5.	How much skill did your mother show as a homemaker?				
6.	How much skill did your mother show in providing for the family, if and when she had to?				

Comment on difficulties specified and others as necessary

III. **Marriage or Living Partner Arrangement**

How long have you been together? _____

Conflict with spouse over:-

Check appropriate box: NONE LITTLE MODERATE GREAT

1	Religion				
2	Drinking				
3	Money				
4	Sex				
5	Relatives / In-laws				
6	How to handle differences of opinions				
7	Excessive control & jealousy				
8	Other areas (indicate)				

Comment on difficulties specified and others as necessary

IV. **Relationship with Partner**

How do you relate to your partner?

Check appropriate box: NONE LITTLE MODERATE GREAT

1.	How much do you talk with & confide in your partner?				
2	How much do you think your partner feels loved and accepted by you?				
3.	How many activities do you engage in with your partner?				
4.	How much affection and praise do you give to your partner				
5.	How much skill do you show as a homemaker?				
6.	How much skill do you show in providing for the family, if and when you have to?				

Comment on difficulties specified and others as necessary

How does your partner relate to you?

1.	How much does your partner talk with & confide in you?				
2	How much do you feel your partner loves and accepts you?				
3.	How many activities does your partner engage in with you?				
4.	How much affection and praise does your partner give to you?				
5.	How much skill does your partner show as a homemaker?				
6.	How much skill does your partner show in providing for the family, if and when he/she has to?				

Comment on difficulties specified and others as necessary

V. **Relationship with your Children**

Check appropriate box: Very Little Moderate Great
Little

1	How adequate do you feel as a parent?				
2	How much conflict do you have with your spouse or partner over problems of training & discipline of children?				
3.	How much personal satisfaction do you derive from being a parent?				
4.	How much do your children feel loved and accepted by you?				
5.	How much do you talk with your children?				
6.	How many activities do you engage in with your children?				
7.	How much affection and praise do you give your children?				
8.	How much do your children confide in you?				
9.	How much responsibility do you give to your children in the home?				
10.	How many conflicts do your adolescent or young adult children have with you over independence and trust?				
11.	How much do your children apply themselves to their responsibilities home, school, church community, etc.?				

Comment on difficulties specified and others as necessary.

EDUCATION: (Last grade completed, or certification earned)

Last or Current Institution Attended	Year Completed	SSC, GCE/CXC or 'A' Level Subjects or other certificate (or state current level)	Average Grade (circle one)
_____	_____	_____	
_____	_____	_____	A B C D
_____	_____	_____	A B C D

PAST PSYCHIATRIC HISTORY

Have you ever had previous emotional symptoms that have disturbed your functioning or caused you to see a doctor or counsellor? Yes / No
 Include suicide attempts: Have you had any? yes/no

Year	Complaint/Diagnosis	Duration	Related Stress Situation	Professional seen and service given	Names & Amounts of medication	Results
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

PREVIOUS PSYCHIATRIC HOSPITALIZATION

Year	Hospital	Duration	Diagnosis given	Names and amounts of medication	Name of doctor
_____	_____	_____	yes/no	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY HISTORY OF EMOTIONAL PROBLEMS OR PSYCHIATRIC ILLNESSES

Relationship	Maternal or Paternal	yes/no	Type of Problem or Illness Known
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICAL ILLNESSES

Year discovered	Diagnosis	Surgery performed and/or medication	Name of doctor	Current degree of control
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PAST MEDICAL HISTORY

Year	Complaint/Diagnosis	Duration	Professional seen and service given (include medication)	Was surgery performed? (yes/no)	Results of treatment
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CHEMICAL USE

yes/no

1. Have you ever felt the need to cut down on your drinking? No Yes
2. Have you ever felt annoyed by criticism of your drinking? No Yes
3. Have you ever felt guilty about your drinking? No Yes
4. Have you ever taken a morning "eye-opener"? No Yes
5. How much beer, wine, or hard liquor do you consume each week, on average? _____
6. How much tobacco do you smoke or chew each week? _____
7. Which drugs (not medications prescribed to you) have you used in the last 10 years? _____

Please provide details about your current use of these drugs or other chemicals, such as amounts, how often you use them, how much, their effects, and so forth: _____

ABUSE HISTORY

I was not abused in any way. I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molestation, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LIVING SITUATION

HOUSING: Owned () Owned by family of origin () Rented / Leased ()
 Boarding () Temporary ()
 Other

MEMBERS OF HOUSEHOLD:

Relationship (e.g. spouse, parent, child, aunt, etc.)	Sex	Age	Rate your relationship with that person			
			Not good	Moderate	Good	Very Good

Comment on difficult relationships. Include and indicate *past* and *present* problems that are significant.

CULTURAL HISTORY

How do you feel about your racial/ethnic background?

What experiences have you had with regard to your racial/ethnic background?

At home _____

school _____

community _____

workplace _____

church _____

other settings _____

How have you identified with your racial/ethnic heritage?

What has been your experience with cultural and religious beliefs and practices related to your racial/ethnic background?

CURRENT CONCERNS

What are the *major symptoms* and *problems* that have brought you here?

(Use “Symptoms and Concerns” questionnaire to assist)

Symptoms:

Problems:

List five things about yourself that *you would like to change*.

(Use “Symptoms and Concerns” questionnaire to assist)

What *solutions or efforts* have you *tried* to solve the problems that bring you here? State benefits, if any.

If you have a preference for one or more of the following methods, please indicate:

- 1. Individual counselling [] 2. Marital or relationship counselling [] 3. Group counselling []
- 4. Workshop/topic discussion []

SPIRITUAL ASSESSMENT

Dr. E. Anthony Allen
Consultant Psychiatrist

Name: _____

SELF-UNDERSTANDING

What is *most important* to you in life?

IDENTIFICATION

Do you belong to any *specific religion or denomination*? If so which?

OVERVIEW

Share about *your spiritual life*.

(If one is intentionally not spiritually involved then the other questions need not be pursued.)

What does your spirituality mean to you?

PRACTICES

How regularly do you attend your *place of worship*?

How regular are your *devotional activities*?

- the reading of your scriptures _____

- prayer and meditation _____

In what *other spiritual activities* are you involved?

FAITH

How do you *feel about God*?

EXPERIENCE

How has He *been to you*?

If you don't believe in God, what is your understanding of who or what you consider is most supreme in the order of life?

How has(ve) this/these being(s) or entity(ies) affected your life?

PROBLEMS

Are you having any *spiritual problems*?

If so, do you wish to discuss them?

What are they? _____

GOALS OF GROWTH

What *goals*, if any, do you wish to set for your future spiritual growth?

Whom, if anyone, would you seek *assistance* from?

EXISTENTIAL CONCERNS

How do you *feel about life*?

How do you feel about *the future*?

What do you see as the *main purpose* of your life?

What feeling do you have about *the end of life*?

STRENGTHS

List five things you like about yourself or that others have complimented you about.

List five good things about your life circumstances.

What are your major strengths? (e.g. abilities, skills, physical attributes, character, personality, spirituality)

What are your major interests and hobbies?
