

# DANIEL SINGLEY, Ph.D.

LICENSED PSYCHOLOGIST, PSY20995

## CLIENT INFORMATION

<b>Name:</b> _____ (Last) (First) (Middle Initial)		<b>Birth Date:</b> ____/____/____	
<b>Age:</b> _____		<b>Gender:</b> _____	
<b>Relationship/Marital Status:</b> _____			
<b>Ethnicity:</b> _____			
<b>Local Address:</b> _____ (Street and Number) (City) (State) (Zip)			
<b>Home Phone:</b> (____) _____ - _____		<b>May we leave a msg?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Cell or Other Phone:</b> (____) _____ - _____		<b>May we leave a msg?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>E-mail:</b> _____ <small>*Please be aware that email might not be confidential.</small>		<b>May we email you?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Emergency Contact Name:</b> _____		<b>Relationship:</b> _____	
<b>Address:</b> _____ (Street and Number) (City) (State) (Zip)		<b>Phone:</b> (____) _____ - _____	
<b>Education:</b> _____ (Please indicate highest degree earned and area of study)		<b>Employment:</b> _____ (Please indicate current job title)	
<b>Disability Status:</b> _____ (Indicate documented mental/physical disability )		<b>Insurance:</b> _____ (Name of carrier) _____/_____/_____ (Policy Number) (Group Number) (Expiration Date)	
<b>Military Duty (if applicable) Active Date:</b> _____ <b>Retired:</b> _____ <b>Service Branch:</b> _____			
<b>Referred by:</b> <input type="checkbox"/> Self <input type="checkbox"/> Employer/Colleague <input type="checkbox"/> Friend <input type="checkbox"/> Police/Judge <input type="checkbox"/> Physician <input type="checkbox"/> Insurance <input type="checkbox"/> Family <input type="checkbox"/> Other _____			
<b>Are you currently receiving psychiatric services or psychotherapy elsewhere?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Have you had previous psychological counseling?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Are you currently taking prescribed psychiatric medication (antidepressants or others)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>If no, have you ever, at any time been previously prescribed psychiatric medication?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Have you or any member of your family been hospitalized for psychiatric reasons?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>I understand that I am responsible for all fees owed to Daniel Singley, Ph.D., Licensed Psychologist, #PSY20995, for professional services rendered to the above patient. I also understand that any appointment not cancelled within 48 hours will be charged for, and, further, charges are expected to be paid at the time services are rendered. I also understand and waive my right to confidentiality if a collection service or court action becomes necessary to collect my delinquent account.</b>			
<b>SIGNATURE OF RESPONSIBLE PARTY:</b> _____		<b>Date:</b> _____	

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## LIFE FUNCTIONING INVENTORY

The information you provide will help in the planning of your therapy.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

### CULTURAL BACKGROUND

1. What is your **ethnic identity**? \_\_\_\_\_

2. How much do you identify with your **ethnic heritage**? (Circle one):

Not at all                  A little                  Somewhat                  Moderately                  Strongly

3. **Religious preference**: \_\_\_\_\_

Are you currently active in your religion?     Yes     Somewhat     No

4. Does your family **speak a language** other than English at home? (Circle one):

Not at all                  Very little                  Sometimes                  Frequently                  Always

If "Sometimes" to "Always", what language is spoken? \_\_\_\_\_

5. Were you and both your biological parents **born in the USA**?     Yes     No     Unsure

If no, who was foreign-born, where and what was the approximate age of immigration to the USA? (e.g. myself, Korea, 12; father Korea, 40; etc.) International students check here

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

### PROBLEM ANALYSIS

1. **PROBLEM DESCRIPTION**: Briefly **describe the problem** you most wish help with right now:

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

2. **PROBLEM INTENSITY**: How would you **rate the intensity** of the problem or concern that brought you in?  
(Circle the appropriate number):

1                          2                          3                          4                          5                          6  
Not Intense                          Moderately Intense                          Extremely Intense

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3. PROBLEM DURATION: Approximately **how long** have you had the current problem? \_\_\_\_\_
4. COPING ATTEMPTS: In what ways have you attempted to cope with this problem?  
\_\_\_\_\_  
\_\_\_\_\_

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## FAMILY BACKGROUND

1. Please list the **members** of your current family, including ages and occupations (e.g. father, 42, Lawyer; stepmother, 40, teacher; brother 16, student; etc.)  
\_\_\_\_\_  
\_\_\_\_\_

2. Please check any past, present, or impending special problems in your family:

- |   |  |
|---|--|
| <input type="checkbox"/> deaths                             | <input type="checkbox"/> physical/sexual abuse         |
| <input type="checkbox"/> divorce                            | <input type="checkbox"/> financial crisis/unemployment |
| <input type="checkbox"/> frequent relocations               | <input type="checkbox"/> legal problems                |
| <input type="checkbox"/> debilitating injuries/disabilities | <input type="checkbox"/> attempted/completed suicide   |
| <input type="checkbox"/> alcohol/drug abuse                 | <input type="checkbox"/> eating disorders              |
| <input type="checkbox"/> serious illness                    | <input type="checkbox"/> other _____                   |
| <input type="checkbox"/> psychiatric disorder               |  |

Please specify family member(s), which special problem, and approximate year of occurrence (e.g. mother-serious illness, 1998, etc.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Have you personally experienced significant **family abuse**?

- none       unsure       emotional       physical       sexual

4. Have you personally experienced **legal problems**?       No       Yes

5. Did you experience **learning problems** in elementary or high school, or college? (Circle one):

- None      Little      Some      Substantial      Lots, constant struggle

6. In general, how **happy or adjusted** were you growing up? (Circle one):

- Poor      Unsatisfactory      About average      Substantial      Completely

7. How much is your immediate family a source of **emotional support** for you? (Circle one):

- None      Little      Somewhat      Substantial      Very Strong

8. How much **conflict in values** do you currently experience with your parents? (Circle one):

- Very little or none      Some      Moderate      Strong      Extreme

9. Who in your family do you currently **feel closest** to? \_\_\_\_\_

Most **distant** from? \_\_\_\_\_ In most **conflict** with? \_\_\_\_\_

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## HEALTH AND SOCIAL ISSUES

1. How is your **physical health** at present?  Poor  Unsatisfactory  Satisfactory  Good  Very good
2. When was your most recent **physical** or visit with a physician? \_\_\_\_\_
3. Please list any **persistent physical symptoms** or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): \_\_\_\_\_
4. Are you presently taking any **prescribed medication**?  No  Yes  
please  
indicate \_\_\_\_\_
5. Are you having any problems with your **sleep habits**?  No  Yes  
(If yes, check where applicable):  Sleeping too little  Sleeping too much  Poor quality sleep  
 Disturbing dreams  Other
6. How many times per week do you **exercise**? \_\_\_\_\_ For about how long each time? \_\_\_\_\_
7. Are you having any difficulty with **appetite or eating habits**?  No  Yes  
(If yes, check where applicable):  Eating less  Eating more  Binging  Restricting  
 Significant weight change (last 2 months)
8. Do you regularly use **alcohol**?  Yes  No  
In a typical month, how often do you have 4 or more drinks in a 24 hour period? \_\_\_\_\_  
Do you consider your alcohol consumption a problem?  Yes  No  Unsure
9. How often do you engage in **recreational drug use**?  Daily  Weekly  Monthly  Rarely  Never  
Do you consider this drug use a problem?  Yes  No  Unsure
10. Do you have any problems or worries about **sexual functioning**?  No  Yes  
(If yes, check where applicable):  Lack of desire  Performance Problem  Sexual Impulsiveness  
 Difficulties maintaining arousal  Worried about sexually transmitted disease  Other
11. Have you ever experienced **sexual assault, unwanted sex or uncomfortable touching**?  
 Frequently  A few times  Once  Never  Unsure
12. Have you had **suicidal thoughts** recently?  Frequently  Sometimes  Rarely  Never  
Have you had them in the past?  Frequently  Sometimes  Rarely  Never
13. Have you ever intentionally **inflicted any harm upon yourself**?  Yes  No  Unsure
14. In the past, how would you rate the quality of your **peer relationships**?  
 Very Poor  Unsatisfactory  About Average  Good  Excellent
15. Approximately how many **significant intimate relationships** (e.g. lasting 6 months or more) have you been involved in? \_\_\_\_\_  
Are you in one now?  Yes  No  I think so
16. Besides family members, approximately how many people can you really count on right now for **friendship or emotional support**? \_\_\_\_\_

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Looking back over the last week, including today, help me understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Session # \_\_\_\_\_ Date: \_\_\_\_\_

Do not mark this area

	Never	Rarely	Sometimes	Frequently	Almost Always	SD	IR	SR
1. I get along well with others.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0		<input type="checkbox"/>	
2. I tire quickly.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
3. I feel no interest in things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
4. I feel stressed at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
5. I blame myself for things.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
6. I feel irritated.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
7. I feel unhappy in my marriage/significant relationship.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4		<input type="checkbox"/>	
8. I have thoughts of ending my life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
9. I feel weak.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
10. I feel fearful.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never.")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
12. I find my work/school satisfying.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
13. I am a happy person.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
14. I work/study too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
15. I feel worthless.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
16. I am concerned about family troubles.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
17. I have an unfulfilling sex life.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
18. I feel lonely.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
19. I have frequent arguments.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
20. I feel loved and wanted.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
21. I enjoy my spare time.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			<input type="checkbox"/>
22. I have difficulty concentrating.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
23. I feel hopeless about the future.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
24. I like myself.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
25. Disturbing thoughts come into my mind that I cannot get rid of.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never.")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
27. I have an upset stomach.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
28. I am not working/studying as well as I used to.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			<input type="checkbox"/>
29. My heart pounds too much.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
30. I have trouble getting along with friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
31. I am satisfied with my life.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
32. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never.")	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
33. I feel that something bad is going to happen.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
34. I have sore muscles.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
35. I feel afraid of open spaces, or driving, or being on buses, subways, and so forth.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
36. I feel nervous.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
37. I feel my love relationships are full and complete.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
38. I feel that I am not doing well at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
39. I have too many disagreements at work/school.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
40. I feel something is wrong with my mind.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
41. I have trouble falling asleep or staying asleep.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
42. I feel blue.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
43. I am satisfied with my relationships with others.	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0			
44. I feel angry enough at work/school to do something I may regret.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			
45. I have headaches.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4			

Developed by Michael J. Lambert, Ph.D, and Gary M. Burlingame, Ph.D.  
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 (ATT Voice Mail): 1-500-488-APCS(2727)

+ +

Total =

Which of the above concerns are most **important** to you?  
 (Write the numbers of the 3 most important concerns in the given spaces)  
 Most important: \_\_\_\_\_ Second most: \_\_\_\_\_ Third most: \_\_\_\_\_