The Center for Men's Excellence
Psychological Science with Proven Results

CLIENT INFORMATION

Name:______________________ (Last) (First) (Middle Initial)	**Birth Date:** ______ /______ /______
Age: ________ **Gender:**_____________ **Relationship/Marital Status:**_________________	
Ethnicity: ______________________________________	
Local Address:______________________________________ (Street and Number) (City) (State) (Zip)	
Home Phone: (______)_____-______________	**May we leave a msg?** ☐Yes ☐No
Cell or Other Phone: (______)_____-______________	**May we leave a msg?** ☐Yes ☐No
E-mail:_______________________________ *Please be aware that email might not be confidential.	**May we email you?** ☐Yes ☐No
Emergency Contact Name:__________________ **Address:**______________________ (Street and Number) (City) (State) (Zip)	**Relationship:**__________________________ **Phone:** (______)_____-________________
Education:______________________________ (Please indicate highest degree earned and area of study)	**Employment:**_________________________ (Please indicate current job title)
Disability Status:____________________________ (Indicate documented mental/physical disability)	**Insurance:**____________________________ (Name of carrier) ____________/______________/__________ (Policy Number) (Group Number) (Expiration Date)
Military Duty (if applicable) **Active Date:**_____________ **Retired:**_______________ **Service Branch:**___________	
Referred by: ☐Self ☐ Other_____________________________________	
Are you currently receiving psychiatric services or psychotherapy elsewhere? ☐Yes ☐No	
Have you had previous psychological counseling? ☐Yes ☐No **Are you currently taking prescribed psychiatric medication (antidepressants or others)?** ☐Yes ☐No **If no, have you ever, at any time been previously prescribed psychiatric medication?** ☐Yes ☐No **Have you or any member of your family been hospitalized for psychiatric reasons?** ☐Yes ☐No	
I understand that I am responsible for all fees owed to my therapist at the Center for Men's Excellence, for professional services rendered to the above patient. I also understand that any appointment not cancelled within 48 hours will be charged for, and that 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. **SIGNATURE OF RESPONSIBLE PARTY:**_____________________ **Date:**________________	

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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 your 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

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?
   ____
   ____

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:

   ☐ deaths
   ☐ divorce
   ☐ frequent relocations
   ☐ debilitating injuries/disabilities
   ☐ alcohol/drug abuse
   ☐ serious illness
   ☐ psychiatric disorder
   ☐ physical/sexual abuse
   ☐ financial crisis/unemployment
   ☐ legal problems
   ☐ attempted/completed suicide
   ☐ eating disorders
   ☐ other ______________________

   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 or significant other, approximately how many people can you really count on right now for **friendship or emotional support**? _____________

ADVERSE CHILDHOOD EVENTS
While you were growing up, <u>during your first 18 years of life</u>:

1. Did a parent or other adult in the household **often or very often**…
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
☐Yes ☐No

2. Did a parent or other adult in the household **often or very often**…
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
☐Yes ☐No

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Attempt or actually have oral, anal, or vaginal intercourse with you?
☐Yes ☐No

4. Did you **often or very often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
☐Yes ☐No

5. Did you **often or very often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
☐Yes ☐No

6. Were your parents **ever** separated or divorced?
☐Yes ☐No

7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit at least a few minutes or threatened with a gun or knife?
☐Yes ☐No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
☐Yes ☐No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
☐Yes ☐No

10. Did a household member go to prison?
☐Yes ☐No

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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.

Do not mark this area

Session # _____ Date: ________

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

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Developed by Michael J. Lambert, Ph.D, and Gary M. Burlingame, Ph.D.

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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: _________

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