Breathe Mind Body Therapy

SELF REPORT FORM

Today's Date: Your Name:

Please help me to understand your needs by sharing the following information. Please attempt to answer all the questions.

1) Current Concerns (What are the main reasons you are seeking help?)

	Primary Issue	**Important Issue**
Personal/Emotional Issues	☐	☐
Family Relationships	☐	☐
Career Problems	☐	☐
Marital/Partner Issues	☐	☐
Behavioral Problems	☐	☐
Health Problems	☐	☐
Other Life Stressors	☐	☐

Other:____

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How long have these problems been going on?____________________________

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What have you done to address these problems?__________________________

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What do you think is causing these problems?______________________________

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Have you experienced any major life changes in the past few months?

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2) Symptom Checklist:
Cognitive:

- ☐ Problems remembering
- ☐ Problems concentrating
- ☐ Confused thinking
- ☐ Disturbing thoughts
- ☐ Recurring thoughts
- ☐ Disorganized thoughts
- ☐ Can't stay focused
- ☐ Do things without thinking/ impulsive
- ☐ See or hear things others don't
- ☐ Problems with decision making/judgment

Physical:

- ☐ Difficulty Falling Asleep
- ☐ Nightmares/Night terrors
- ☐ Tired often
- ☐ Excessive Sleep
- ☐ Wake-up During the Night
- ☐ Nervous or tense
- ☐ Racing heart
- ☐ Headaches
- ☐ Migraine headaches
- ☐ Stomachaches
- ☐ Constant pain
- ☐ Hard time sitting still
- ☐ Problem staying on task
- ☐ Shaking/trembling
- ☐ Not feeling good enough
- ☐ Sensory Hypersensitivity (sight, sound touch)
- ☐ Sensory Hypersensitivity (sight, sound touch)
- ☐ Additional Physical Complaints (Specify)

Dietary Concerns:

- ☐ Eat Excessively
- ☐ Eat Non-food Items
- ☐ Food Refusal
- ☐ Food Related Sensory Concerns
- ☐ Hard to Please (Food)
- ☐ Hoard Food
- ☐ Poor Appetite
- ☐ Purge
- ☐ Binge
- ☐ Restrict Food Intake
- ☐ Vomits
- ☐ Weight Gain/Loss
- ☐ Other (specify)

Emotional:

- ☐ Feeling panic or fear
- ☐ Feeling anxious
- ☐ Worrying
- ☐ Sadness or depressed
- ☐ Irritable
- ☐ Angry easily or often
- ☐ Feeling worthless
- ☐ Feeling hopeless
- ☐ Not feeling confident
- ☐ Feeling helpless
- ☐ Mood changes/swings
- ☐ Wanting to hurt self
- ☐ Cutting or other self harm
- ☐ Feelings of wanting to die
- ☐ Feelings of stress
- ☐ Grief or loss

Relational:

- ☐ Problem at work
- ☐ Problem with completing work
- ☐ Problems at home
- ☐ Not getting along with others
- ☐ Lack of friends
- ☐ Shy around others
- ☐ Hitting/fighting
- ☐ Not wanting to be around others
- ☐ Concerns about sexual feelings or identity
- ☐ Concerns about gender
- ☐ Problems with sexual thoughts/ behavior
- ☐ Lying a lot
- ☐ Wanting to harm others
- ☐ Abused by others
- ☐ Drug/alcohol abuse/use
- ☐ Other addictive behavior
- ☐ Illegal behavior
- ☐ Concerns about family members

Any history of suicidality/homicidality? ☐ Yes ☐ No

Suicide attempt(s)? ☐ Yes ☐ No

How/when?____

Current suicidal thoughts? ☐ Yes ☐ No

Plan?____

Homicidal/violent thoughts/plans? ☐ Yes ☐ No

Describe:____

3) What do you want to accomplish/What would make your life better?

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4) What are your strengths?

5) What are your areas of opportunity?

6) Please share anything else that you feel is important for me to know.

7) Other Health Concerns:

Food or Environmental Allergies:

☐ No

☐ Yes (Specify):

Health Concerns:

☐ Asthma ☐ Chronic Ear Infections ☐ Diabetes

☐ Hearing Problems ☐ Hypothyroidism/Hyperthyroidism

☐ Migraine Headaches ☐ Reflux ☐ Seizures

☐ Vision Problems ☐ Vitamin D Deficiency

☐ Frequent Injuries: ____

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☐ Relevant Medical History (head injuries, surgeries, birth defects, physical illnesses): ________

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8) Mental Health History:

Outpatient Mental Health Services:	☐ not applicable	☐ current	☐ past
Inpatient Mental Health Services:	☐ not applicable	☐ current	☐ past
Treatment for Substance Use/Abuse:	☐ not applicable	☐ current	☐ past
Previous Family Therapy:	☐ not applicable	☐ current	☐ past
Psychiatric Services:	☐ not applicable	☐ current	☐ past
Taken psychiatric medication:	☐ No	☐ Yes	

(Drug name/dosage/dates)

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10) Substance Use/Abuse History:

Alcohol Use: ☐ None ☐ Monthly ☐ Weekly ☐ Daily

How much: ☐ None ☐ 1-2 ☐ 3-5 ☐ More than 5

Drink of choice: ☐ Beer ☐ Wine ☐ Hard Liquor

Do you think your use is a problem? ☐ Yes ☐ No ☐ Unsure

Drug Use: Marijuana: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

Other non-prescription substances: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

If yes, list what substances____

Prescription drugs used not as prescribed: ☐ None ☐ Occasionally ☐ Weekly ☐ Daily

If yes, what prescriptions____

Cigarettes: ☐ None ☐ Monthly ☐ Weekly ☐ Daily

Caffeine/Energy Drinks: ☐ None ☐ Monthly ☐ Weekly ☐ Daily

Who lives in your household?

NAME	AGE	RELATIONSHIP TO YOU

11) Positive Supports and Strengths

☐ Supportive Friends ☐ Supportive Relatives ☐ Hobbies (Specify)

☐ Spiritual Activities ☐ Organized Activities ☐ Positive Coping Skills

☐ Other Natural Supports(Specify):

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12) Family Mental Health and Substance Abuse History:

Has a family member had mental health problems? ☐ No ☐ Yes (Please explain):

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Has a family member had substance use/abuse problems? ☐ No ☐ Yes (Please explain):

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13) Psycho-Social History and Risk Factors:
Have you experienced any of the following abuse, trauma, or difficult life circumstances?

Exposure to domestic violence:	☐ not applicable	☐ current	☐ past
Exposure to community violence:	☐ not applicable	☐ current	☐ past
Victim of community violence:	☐ not applicable	☐ current	☐ past
Witness to the abuse of others:	☐ not applicable	☐ current	☐ past
Unsafe neighborhood:	☐ not applicable	☐ current	☐ past
Victim of a crime:	☐ not applicable	☐ current	☐ past
Victim of disaster/terrorism:	☐ not applicable	☐ current	☐ past
Homeless:	☐ not applicable	☐ current	☐ past
Multiple Family Moves:	☐ not applicable	☐ current	☐ past
Relocated from another country:	☐ not applicable	☐ current	☐ past
Living in poverty:	☐ not applicable	☐ current	☐ past
Serious illness in client:	☐ not applicable	☐ current	☐ past
Serious illness in family:	☐ not applicable	☐ current	☐ past
Death of a loved one:	☐ not applicable	☐ current	☐ past
Family legal difficulties/custody issues:	☐ not applicable	☐ current	☐ past
Client legal difficulties:	☐ not applicable	☐ current	☐ past
Alleged victim of physical abuse:	☐ not applicable	☐ current	☐ past
Alleged victim of sexual abuse:	☐ not applicable	☐ current	☐ past
Alleged victim of neglect:	☐ not applicable	☐ current	☐ past
Relationships with severe conflict:	☐ not applicable	☐ current	☐ past
Lack of resources:	☐ not applicable	☐ current	☐ past
Social isolation:	☐ not applicable	☐ current	☐ past
Disruption to attachment relationship:	☐ not applicable	☐ current	☐ past
History of Child Welfare involvement:	☐ not applicable	☐ current	☐ past
History of out-of-home placement:	☐ not applicable	☐ current	☐ past
History of foster placements:	☐ not applicable	☐ current	☐ past

If known, number of foster placements: ___________