Robert H. Tinker, Ph.D., P.C.
18 East Monument Street
Colorado Springs, CO 80903

The purpose of this questionnaire is to obtain information about you and your background. In psychotherapy, accurate records are necessary since they permit a more thorough understanding of you. Completing these questions as fully and as accurately as you can is greatly appreciated. Case records are strictly confidential.

NO OUTSIDER IS PERMITTED TO SEE YOUR CASE RECORDS WITHOUT YOUR <u>WRITTEN</u> PERMISSION.

Who referred you to Dr. Tinker?_____

1. GENERAL INFORMATION:

Name_____ Birthdate:_____

Address:_____

Telephone Numbers: (Days)_____ (Evenings)_____

Gender: M_____ F_____ Age:_____ Occupation:_____

Education: Highest Grade completed:_____ Veteran: Yes_____ No_____ War_____

Marital Status (circle one): Single Cohabitation Married

Separated (Date:_____) Divorced (Date:_____) Widowed (Date:_____)

Partner's Name/occupation (optional):_____

Children's Names/Ages:_____

Single Parent: Yes_____ No_____ Grandparent: Yes_____ No_____

2. PERSONAL AND SOCIAL HISTORY

(a) Previous Occupations: _____

_____

(b) Extended Unemployment: Yes_____ No_____

Reasons:_____

_____

(c) Annual Family Income:

$0 to 10,000	_____	$30,000 to 35,000	_____
10,000 to 15,000	_____	35,000 to 40,000	_____
15,000 to 20,000	_____	40,000 to 45,000	_____
20,000 to 25,000	_____	45,000 to 50,000	_____
25,000 to 30,000	_____	50,000 or above	_____

(d) Financially Stable: Yes_____ No_____

(e) Health Insurance? Yes_____ No_____ Company:_____

(f) **Mother:** Name_____ Age:_____

Father: Name_____ Age:_____

Occupation: (M)_____ (F)_____

Mother Deceased?_____ Date:_____ Father Deceased?_____ Date:_____

(g) Siblings: Brothers (how many?) _____ Ages:_____

Sisters (how many?) _____ Ages:_____

3. PYSICAL

Height_____ Weight_____ Current Medication(s)_____

_____

Are you pregnant? Yes_____ No_____ Due date:_____

Do you have any current physical health problems? If so, please specify:_____

_____

_____

Do you have any handicaps? No_____ Yes_____

Do you wear contacts or glasses? No_____ Yes_____

Do you have eye problems? No_____ Yes_____

Do you have epilepsy? No_____ Yes_____

Do you have any disability? No_____ Yes_____

Have you ever had any head injuries or loss of consciousness? If so, please give details:_____

_____

_____

Type of injury:_____ Date:_____

Check any of the following that **often** apply to you:

____ Headaches
____Dizziness
____Palpitations
____Muscle spasms
____Tension
____Sexual disturbances
____Unable to relax
____Constipation
____Tingling
____Numbness
____Diarrhea
____Hearing problem
____Stomach trouble
____Tics
____Fatigue
____Twitches
____Back pain
____Tremors
____Fainting spells
____Hear things
____Watery eyes
____Flushes
____Lump in throat
____Skin problems
____Dry mouth
____Burning or itching skin
____Chest pains
____Rapid heart beat
____Don't like being touched
____Blackouts
____Excessive sweating
____Visual disturbance
____Loss of memory
____Sighing

Please list any medications you have taken during the past six months (including aspirin, birth control pills, or any medicines that were prescribed or taken over the counter):_____

_____

Check any of the following that have applied to you in the past month:

DRUGS

	Never	Rarely	Occasionally	Frequently
Marijuana				
Tranquilizers				
Sedatives				
Aspirin				
Cocaine				
Painkillers				

	Never	Rarely	Occasionally	Frequently
Alcohol				
Caffeine				
Cigarettes				
Narcotics				
Stimulants				
Hallucinogens (LSD, etc.)				

SYMPTOMS

Allergies				
Ulcers				
Heartburn				
High blood pressure				
Heart problems				
Nausea				
Vomiting				
Insomnia				
Early morning awakening				
Fitful sleep				
Overeating				
Poor appetite				

4. BEHAVIOR AND FEELINGS

Check any that have been a serious experience for you:

____Learning problems (lately)
____School problems
____Unhappy childhood
____Physical problems
____Emotional problems
____Behavior problems
____Family problems
____Eating disorders
____Problems with friends
____Physical abuse
____Emotional abuse
____Drug abuse
____Alcohol abuse
____Sexual abuse
____Rape
____Legal problems
____Loneliness
____Anger
____Anger
____Rage
____Sadness
____Sexual issues

Check any of the following behaviors that have applied to you in the past month:

____Sleep disturbance
____Concentration difficulties
____Vomiting
____Suicide attempts
____Eating problems
____Impulsive actions
____Phobic avoidance
____Crying
____Temper outbursts
____Working too hard
____Loss of control
____Nervous tics
____Procrastination
____Insomnia
____Withdrawal
____Drug abuse
____Compulsions
____Risk taking
____Laziness

Check any of the following feelings that often apply to you:

____Angry	____Guilty	____Unhappy
____Annoyed	____Happy	____Bored
____Sad	____Conflicted	____Restless
____Depressed	____Regretful	____Lonely
____Anxious	____Hopeless	____Contented
____Fearful	____Hopeful	____Excited
____Panicky	____Helpless	____Optimistic
____Energetic	____Relaxed	____Tense
____Envy	____Jealous	

____Other:_____

(a) Have you ever been hospitalized for psychological problems? Yes_____ No_____

If so, when and where?_____

(b) Have you ever attempted suicide? Yes_____ No_____ Number of times:_____

(c) List your main fears:

1.
2.
3.

5. DESCRIPTION OF TRAUMATIC MEMORY

What is the traumatic memory about? Does it continue to interfere with your life? How? _____

_____

_____

_____

_____

_____

_____

_____

When did your trauma occur (date)? _____

Have you been in therapy before or received any prior help for your trauma? If so, please give name(s), professional title(s), date(s) of treatment(s) and results:

Names	**Date(s)**	**No Improvement (check)**
_____		
_____		
_____		

In case of an emergency, contact:

_____

Name Relationship to you Phone number