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**4500 E 9th Suite 660S**

**Denver, CO 80220**

**BACKGROUND INFORMATION**

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

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

* **Type of work you do: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Interests, recreational activities and hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **What you like to do when you have spare time at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Community involvement(s) (neighborhood, religious, political, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **Number of friends you’d say you have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Health and medical difficulties, past and present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Kind of child you were: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Kind of teenager you were: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Kind of family you grew up in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Prior psychotherapy (if applicable):**
	+ **Therapist(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **Approximate length of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **What you sought help for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **Result(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Main difficulty that has brought you to see us: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **Length of time experiencing this: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Describe any recent losses or significant changes in your life: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **If you have taken medication for psychiatric or emotional problems, please indicate:**
	+ **Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **From whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **For what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
	+ **Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **List any drugs (NOT MEDICATIONS PRESCRIBED FOR YOU) have you used in the last 10 years:**

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* **Provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects and so forth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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* **Describe any family history of mental illness and/or substance abuse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **How much beer, wine or hard liquor you consume each week, on average: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Have you ever felt the need to cut down on your drinking? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No**
* **Have you every felt annoyed by criticism of your drinking? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No**
* **Have you ever felt guilty about your drinking? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No**
* **Have you ever taken a morning “eye-opener”? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No**
* **How much tobacco do you smoke or chew each week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **I am experiencing:**

**\_\_\_\_\_\_ Anger \_\_\_\_\_\_ Irritability**

**\_\_\_\_\_\_ Anxiety \_\_\_\_\_\_ Lack of energy**

* **I have symptoms of:**

**\_\_\_\_\_\_ Compulsive behaviors \_\_\_\_\_\_ Loss of interest**

**\_\_\_\_\_\_ Confusion \_\_\_\_\_\_ Memory loss**

**\_\_\_\_\_\_ Confusion \_\_\_\_\_\_ Mood swings**

**\_\_\_\_\_\_ Depression \_\_\_\_\_\_ Nausea/vomiting**

**\_\_\_\_\_\_ Excessive use of alcohol/drugs \_\_\_\_\_\_ Self-critical**

**\_\_\_\_\_\_ Headaches \_\_\_\_\_\_ Seizures**

**\_\_\_\_\_\_ Hopelessness \_\_\_\_\_\_ Shortness of breath**

**\_\_\_\_\_\_ Impulses to hurt self or other \_\_\_\_\_\_ Sleep difficulties**

**\_\_\_\_\_\_ Disorientation (moments \_\_\_\_\_\_ Sleep difficulties**

 **of not knowing where you are**

**or who you are) \_\_\_\_\_\_ Suicidal thoughts**

**\_\_\_\_\_\_ Hallucinations**

 **(seeing or hearing things) \_\_\_\_\_\_ Suspiciousness**

**\_\_\_\_\_\_ Thought disorder**

**\_\_\_\_\_\_ Obsessive preoccupations or repeated**

 **thoughts**

**\_\_\_\_\_\_ Weight gain or loss**

**\_\_\_\_\_\_ Medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **I have community-related concerns about:**

**\_\_\_\_\_\_ Insufficient friends**

**\_\_\_\_\_\_ Over-extended in friendships or community roles**

**\_\_\_\_\_\_ Tension in friend relationships**

**\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**