The purpose of this inventory is to obtain a comprehensive picture of your background. In psychotherapy records, it is necessary since they permit a more thorough dealing with one's problems. By completing these questions as fully and as accurately as you can, you will facilitate your therapeutic program. You are requested to answer these routine questions in your own time instead of using up your actual consulting time (please feel free to use extra sheets if you need additional answer space).

It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal.

Case records are strictly confidential.
Date: ____________________________

Name: ________________________________________________________________

Address: _________________________________________________________________________________________________

Telephone numbers: Day_____________________________________ Evening________________________________________

Age: ______ Occupation: ___________________________________________________________________ Sex: ___ M ___ F

Date of birth: _______________ Weight: _______ Does your weight fluctuate? ____ Yes ____ No. If yes, by how much? _______

Do you have a family physician? ____ Yes ____ No

Name of family physician: __________________________________________ Telephone number: _________________________

By whom were you referred? __________________________________________________________________________________

Marital status (check one):  ____ Single  ____ Engaged  ____ Married  ____ Separated  ____ Divorced

 ____ Widowed  ____ Living with someone  ____ Remarried: How many times?

Do you live in:  ____ House  ____ Room  ____ Apartment  ____ Other: __________________________________________

With whom do you live? (check all that apply):  ____ Self  ____ Parents  ____ Spouse  ____ Roommate

 ____ Child(ren)  ____ Friend(s)  ____ Others (specify): ______________________________________________________

What sort of work are you doing now? _________________________________________________________________________

Does your present work satisfy you?  ____ Yes  ____ No

If no, please explain: _______________________________________________________________________________________

________________________________________________________________________________________________________

What kinds of jobs have you held in the past? __________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Have you been in therapy before or received any professional assistance for your problems?  ____ Yes  ____ No

Have you ever been hospitalized for psychological/psychiatric problems?  ____ Yes  ____ No

If yes, when and where? ____________________________________________________________

________________________________________________________________________________________________________

Have you ever attempted suicide?  ____ Yes  ____ No

Does any member of your family suffer from an “emotional” or “mental disorder”?  ____ Yes  ____ No

Has any relative attempted or committed suicide?  ____ Yes  ____ No
PERSONAL AND SOCIAL HISTORY

Father:

Name: ________________________________________________________________ Age: ______

Occupation: __________________________________________________________ Health: __________

If deceased, give his age at time of death: __________ How old were you at the time? ______________

Cause of death: ______________________________________________________

Mother:

Name: ________________________________________________________________ Age: ______

Occupation: __________________________________________________________ Health: __________

If deceased, give her age at time of death: __________ How old were you at the time? ______________

Cause of death: ______________________________________________________

Siblings:

Age(s) of brother(s): ____________________________ Age(s) of sister(s): _________________________

Any significant details about siblings: _______________________________________________________

_______________________________________________________________________________________

If you were not brought up by your parents, who raised you and between what years? ______________

_______________________________________________________________________________________

Give a description of your father’s (or father substitute’s) personality and his attitude toward you (past and present):

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Give a description of your mother’s (or mother substitute’s) personality and her attitude toward you (past and present):

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________
In what ways were you disciplined or punished by your parents?

__________________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Give an impression of your home atmosphere (i.e. the home in which you grew up). Mention state of compatibility between parents and between children.

__________________________________________________________________________________

__________________________________________________________________________________

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__________________________________________________________________________________

__________________________________________________________________________________

Were you able to confide in your parents?  ____ Yes  ____ No

Basically, did you feel loved and respected by your parents?  ____ Yes  ____ No

If you have a stepparent, give your age when your parent remarried: __________________________________________

Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc.?  ____ Yes  ____ No

If yes, please describe briefly: ________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Scholastic strengths: _______________________________________________________________________

Scholastic weaknesses: _____________________________________________________________________

What was the last grade completed (or highest degree)? __________________________________________

Check any of the following that applied during your childhood/adolescence:

____ Happy childhood  ____ Not enough friends  ____ Sexually abused

____ Unhappy childhood  ____ School problems  ____ Severely bullied or teased

____ Emotional/behavior problems  ____ Financial problems  ____ Eating disorder

____ Legal trouble  ____ Strong religious convictions  ____ Others: ____________________________

____ Death in family  ____ Drug use  _______________________________________________________

____ Medical problems  ____ Used alcohol  ___________________________________________________

____ Ignored  ____ Severely punished  _______________________________________________________
DESCRIPTION OF PRESENTING PROBLEMS

State in your own words the nature of your main problems: __________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

On the scale below, please estimate the severity of your problem(s):

___ Mildly upsetting  ___ Moderately upsetting  ___ Very severe  ___ Extremely severe  ___ Totally incapacitating

When did your problems begin? _______________________________________________________________________________
__________________________________________________________________________________________________________

What seems to worsen your problems? _________________________________________________________________________
________________________________________________________________________________________________________________________________

What have you tried that has been helpful? ______________________________________________________________________
_________________________________________________________________________________________________________

How satisfied are you with your life as a whole these days?

Not at all satisfied  1  2  3  4  5  6  7  Very satisfied

How would you rate your overall level of tension during the past month?

Relaxed  1  2  3  4  5  6  7 Tense

EXPECTATIONS REGARDING THERAPY

In a few words, what do you think therapy is all about? __________________________________________________________
__________________________________________________________________________________________________________
__________________________________________________________________________________________________________

How long do you think your therapy should last? ________________________________________________________________
__________________________________________________________________________________________________________

What personal qualities do you think the ideal therapist should possess? ____________________________________________
__________________________________________________________________________________________________________
MODALITY ANALYSIS OF CURRENT PROBLEMS

The following section is designed to help you describe your current problems in greater detail and to identify problems that might otherwise go unnoticed. This will enable us to design a comprehensive treatment program and tailor it to your specific needs. The following section is organized according to the seven modalities of Behaviors, Feelings, Physical Sensations, Images, Thoughts, Interpersonal Relationships, and Biological Factors.

BEHAVIORS

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

- ___ Overeat
- ___ Loss of control
- ___ Phobic avoidance
- ___ Crying
- ___ Take drugs
- ___ Suicidal attempts
- ___ Spend too much money
- ___ Outbursts of temper
- ___ Unassertive
- ___ Compulsions
- ___ Can’t keep a job
- ___ Others: __________
- ___ Odd behavior
- ___ Smoke
- ___ Insomnia
- ___ __________
- ___ Drink too much
- ___ Withdrawal
- ___ Take too many risks
- ___ __________
- ___ Work too hard
- ___ Nervous tics
- ___ Lazy
- ___ __________
- ___ Procrastination
- ___ Concentrations difficulties
- ___ Eating Problems
- ___ __________
- ___ Impulsive reactions
- ___ Sleep disturbance
- ___ Aggressive behavior

What are some special talents or skills that you feel proud of? ________________________________________________________________
____________________________________________________________________________________________________

What would you like to stop doing? ____________________________________________________________________________
____________________________________________________________________________________________________

How is your free time spent? __________________________________________________________________________________
____________________________________________________________________________________________________

What kind of hobbies or leisure activities do you enjoy or find relaxing? ________________________________________________
____________________________________________________________________________________________________

Do you have trouble relaxing or enjoying weekends and vacations?   ___ Yes    ___ No
If yes, please explain: __________________________________________________________________________________________
____________________________________________________________________________________________________

If you could have any two wishes, what would they be? ____________________________________________________________________________________________________
____________________________________________________________________________________________________
FEELINGS
Check any of the following feelings that often apply to you:

____ Angry  ____ Fearful  ____ Happy  ____ Hopeful  ____ Bored  ____ Optimistic
____ Annoyed  ____ Panicky  ____ Conflicted  ____ Helpless  ____ Restless  ____ Tense
____ Sad  ____ Energetic  ____ Shameful  ____ Relaxed  ____ Lonely  ____ Others: __________
____ Depressed  ____ Envious  ____ Regretful  ____ Jealous  ____ Contented
____ Anxious  ____ Guilty  ____ Hopeless  ____ Unhappy  ____ Excited

List your five main fears:

1. _____________________________________________________________
2. _____________________________________________________________
3. _____________________________________________________________
4. _____________________________________________________________
5. _____________________________________________________________

What are some positive feelings you have experienced recently? ____________________________

______________________________________________________________________________

______________________________________________________________________________

When are you most likely to lose control of your feelings? ____________________________

______________________________________________________________________________

______________________________________________________________________________

Describe any situations that make you feel calm or relaxed: ____________________________

______________________________________________________________________________

______________________________________________________________________________

PHYSICAL SENSATIONS
Check any of the following physical sensations that often apply to you:

____ Abdominal pain  ___ Bowel disturbances  ____ Hear things  ____ Blackouts
____ Pain or burning with urination  ____ Tingling  ____ Watery eyes  ____ Excessive sweating
____ Menstrual difficulties  ____ Numbness  ____ Flashes  ____ Visual disturbances
____ Headaches  ____ Stomach trouble  ____ Nausea  ____ Hearing problems
____ Dizziness  ____ Tics  ____ Skin problems  ____ Others: __________
____ Palpitations  ____ Fatigue  ____ Dry mouth  _________________________
____ Muscle spasms  ____ Twitches  ____ Burning or itching skin  _________________________
____ Tension  ____ Back pain  ____ Chest pains  _________________________
____ Sexual disturbances  ____ Tremors  ____ Rapid heart beat  _________________________
____ Unable to relax  ____ Fainting spells  ____ Don’t like to be touched  _________________________
What sensations are:

Pleasant to you? _______________________________________________________________

Unpleasant to you? _________________________________________________________________________________________

IMAGES

Check any of the following that apply to you:

I picture myself:

___ Being happy  ___ Being talked about  ___ Being trapped
___ Being hurt  ___ Being aggressive  ___ Being laughed at
___ Not coping  ___ Being helpless  ___ Being promiscuous
___ Succeeding  ___ Hurting others  ___ Others: _____________________________
___ Losing control  ___ Being in charge  _______________________________________
___ Being followed  ___ Failing  _____________________________________________

I have:

___ Pleasant sexual images  ___ Seduction images
___ Unpleasant childhood images  ___ Images of being loved
___ Negative body images  ___ Others: _____________________________
___ Unpleasant sexual images  _____________________________
___ Lonely images  _____________________________

Describe a very pleasant image, mental picture, or fantasy: _______________________________________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

Describe a very unpleasant image, mental picture, or fantasy: _______________________________________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

Describe your image of a completely “safe place”:

_________________________________________________________________________________________________________

Describe any persistent or disturbing images that interfere with your daily functioning: _____________________________

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

How often do you have nightmares? _______________________________________________________________
THOUGHTS

Check each of the following that you might use to describe yourself:

___ Intelligent         ___ A nobody
___ Confident         ___ Useless
___ Worthwhile         ___ Confused
___ Ambitious         ___ Evil
___ Sensitive         ___ Morally degenerate
___ Loyal
___ Trustworthy
___ Full of regrets
___ Worthless

___ Intelligent         ___ A nobody
___ Confident         ___ Useless
___ Worthwhile         ___ Confused
___ Ambitious         ___ Evil
___ Sensitive         ___ Morally degenerate
___ Loyal
___ Trustworthy
___ Full of regrets
___ Worthless

___ Concentration difficulties         ___ Lazy
___ Memory problems         ___ Untrustworthy
___ Confused         ___ Attractive
___ Stupid         ___ Can’t make decisions
___ Naïve         ___ Suicidal ideas
___ Honest         ___ Persevering
___ Incompetent         ___ Good sense of humor
___ Unattractive         ___ Hard working
___ Conflicted         ___ Undesirable

What do you consider to be your craziest thought or idea? __________________________________________________________

What worries do you have that may negatively affect your mood or behavior? ___________________________________________

On each of the following items, please circle the number that most accurately reflects your opinions:

I should not make mistakes. 1 2 3 4 5
I should be good at everything I do. 1 2 3 4 5
When I do not know something, I should pretend that I do. 1 2 3 4 5
I should not disclose personal information. 1 2 3 4 5
I am a victim of circumstances. 1 2 3 4 5
My life is controlled by outside forces. 1 2 3 4 5
Other people are happier than I am. 1 2 3 4 5
It is very important to please other people. 1 2 3 4 5
Play it safe: don’t take any risks. 1 2 3 4 5
I don’t deserve to be happy. 1 2 3 4 5
If I ignore my problems, they will disappear. 1 2 3 4 5
It is my responsibility to make other people happy. 1 2 3 4 5
I should strive for perfection. 1 2 3 4 5
Basically, there are two ways of doing things-the right way and the wrong way. 1 2 3 4 5
I should never be upset. 1 2 3 4 5
INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily?  ____ Yes  ____No
Do you keep them?  ____Yes  ____No

Did you date much during high school?  ____Yes  ____No
College?  ____Yes  ____No

Were you ever bullied or severely teased?  ____ Yes  ____No

Describe any relationship that gives you:
Joy: ______________________________________________________________________________________
________________________________________________________________________________________

Grief: _________________________________________________________________________________________________
________________________________________
________________________________________________________________________________________

Rate the degree to which you generally feel relaxed and comfortable in social situations:
Very relaxed  1  2  3  4  5  6  7  Very anxious

Do you have one or more friends with whom you feel comfortable sharing your most private thoughts?  ____ Yes  ____No

Marriage (or a committed relationship)

How long did you know your spouse before your engagement? ___________________________________________________

How long were you engaged before you got married? ___________________________________________________

How long have you been married? ___________________________________________________

What is your spouse’s age? _____ His/her occupation? ___________________________________________________

Describe your spouse’s personality: ___________________________________________________

________________________________________________________________________________________
________________________________________________________________________________________

What do you like most about your spouse? ___________________________________________________

________________________________________________________________________________________
________________________________________________________________________________________

What do you like least about your spouse? ___________________________________________________

________________________________________________________________________________________
________________________________________________________________________________________

What factors detract from your marital satisfaction? ___________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
On the scale below, please indicate how satisfied you are with your marriage:

<table>
<thead>
<tr>
<th>Very dissatisfied</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Very satisfied</th>
</tr>
</thead>
</table>

How do you get along with your partner’s friends and family?

<table>
<thead>
<tr>
<th>Very poorly</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Very well</th>
</tr>
</thead>
</table>

How many children do you have? ________________________________

Please give their names and ages: __________________________________________________________

Do any of your children present special problems? _____ Yes _____ No

If yes, please describe: ________________________________________________________________

Any significant details about a previous marriage(s)? ______________________________________

____________________________________________________________________________________

Other Relationships

Are there any problems in your relationships with people at work? _____ Yes _____ No

If yes, please describe: ________________________________________________________________

Please complete the following:

One of the ways people hurt me is: ______________________________________________________

I could shock you by: ______________________________________________________________________

My spouse (or boyfriend/girlfriend) would describe me as: ________________________________

My best friend thinks I am: _____________________________________________________________

People who dislike me: ___________________________________________________________________

Are you currently troubled by any past rejections or loss of a love relationship? _____ Yes _____ No

If yes, please explain: ____________________________________________________________________
Do you have any current concerns about your physical health?  ____ Yes  ____ No
If yes, please specify: ____________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please list any medication you are currently taking: ____________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Do you eat three well-balanced meals each day?  ____ Yes  ____ No
Do you get regular physical exercise?  ____ Yes  ____ No
If yes, what type and how often? __________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please list any significant medical problems that apply to you or to members of your family: __________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please describe any surgery you have had (give dates): _________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please describe any physical handicap(s) you have: _________________________________
______________________________________________________________________________
______________________________________________________________________________

**Menstrual History (females)**

Age at first period: _________       Were you informed?  ____ Yes  ____ No        Did it come as a shock?  ____ Yes  ____ No
Are you regular?  ____ Yes  ____ No        Duration: ____________________________ Do you have pain?  ____ Yes  ____ No
Do you periods affect your moods?  ____ Yes  ____ No        Date of last period: ____________________________
Check any of the following that apply to you:

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<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Daily</th>
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<tbody>
<tr>
<td>Muscle weakness</td>
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<tr>
<td>Tranquilizers</td>
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<tr>
<td>Diuretics</td>
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<tr>
<td>Diet pills</td>
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<tr>
<td>Marijuana</td>
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<tr>
<td>Hormones</td>
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<tr>
<td>Sleeping pills</td>
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<tr>
<td>Aspirin</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Pain killers</td>
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<tr>
<td>Narcotics</td>
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<tr>
<td>Stimulants</td>
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<tr>
<td>Hallucinogens (i.e. LSD)</td>
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<tr>
<td>Laxatives</td>
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<tr>
<td>Cigarettes</td>
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<tr>
<td>Tobacco (specify)</td>
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<tr>
<td>Coffee</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Birth control pills</td>
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<tr>
<td>Vitamins</td>
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<tr>
<td>Under eat</td>
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<tr>
<td>Overeat</td>
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<tr>
<td>Eat junk foods</td>
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<tr>
<td>Diarrhea</td>
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<td>Constipation</td>
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<td>Gas</td>
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<tr>
<td>Indigestion</td>
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<tr>
<td>Nausea</td>
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<td>Vomiting</td>
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<td>Heartburn</td>
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<td>Dizziness</td>
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<td>Palpitations</td>
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<td>Fatigue</td>
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<td>Allergies</td>
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<td>High blood pressure</td>
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<tr>
<td>Chest Pain</td>
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<tr>
<td>Shortness of breath</td>
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<td>Insomnia</td>
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<td>Sleep too much</td>
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<tr>
<td>Fitful sleep</td>
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<tr>
<td>Early morning awakening</td>
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<tr>
<td>Earaches</td>
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<td>Headaches</td>
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<tr>
<td>Backaches</td>
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<tr>
<td>Bruise or bleed easily</td>
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<td>Weight problems</td>
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<tr>
<td>Others:</td>
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Others:
**STRUCTURAL PROFILE**

Directions: Rate yourself on the following dimensions on a seven-point scale with “1” being the lowest and “7” being the highest.

| BEHAVIORS: Some people may be described as “doers” – they are action oriented, they like to busy themselves, get things done, take on various projects. How much of a doer are you? | 1 2 3 4 5 6 7 |
| FEELINGS: Some people are very emotional and may or may not express How passionate are you? | 1 2 3 4 5 6 7 |
| PHYSICAL SENSATIONS: Some people attach a lot of value to sensory experiences, such as sex, food, music, art, and other “sensory delights.” Others are very much aware of minor aches, pains and discomforts How “tuned into” your sensations are you? | 1 2 3 4 5 6 7 |
| MENTAL IMAGES: How much fantasy or daydreaming do you engage in? This is separate from thinking or planning. This is “thinking in pictures,” visualizing real or imagined experiences, letting your mind roam. How much are you into imagery? | 1 2 3 4 5 6 7 |
| THOUGHTS: Some people are very analytical and like to plan things. They like to reason things through. How much of a ‘thinker” and “planner” are you? | 1 2 3 4 5 6 7 |
| INTERPERSONAL RELATIONSHIPS: How important are other people to you? This is you self-rating as a social being. How important are close friendships’ To you, the tendency to gravitate toward people, the desire for intimacy? The opposite of this is being a “loner.” | 1 2 3 4 5 6 7 |
| BIOLOGICAL FACTORS: Are you healthy and health conscious? Do you avoid bad habits like smoking, too much alcohol, drinking a lot of coffee, overeating, etc.? Do you exercise regularly, get enough sleep, avoid junk foods, and generally take care of your body? | 1 2 3 4 5 6 7 |
Please describe any significant childhood (or other) memories and experiences you think your therapist should be aware of: