DAVID N. MAX, Ph.D. (510) 428-1671
Clinical Psychologist 3120 Telegraph Ave., Suite 12 • Berkeley, CA 94705 | 347 Noe Street • San Francisco, CA 94114

GENERAL INFORMATION Date: _____

Name: _____ DOB: _____ Age: _____

Street Address: _____ City: _____ Zip: _____

Telephone Numbers: Day_____ Evening: _____ Cell: _____

Gender: _____ Preferred Pronoun: _____ Sexual Orientation: _____

Ethnic Identity: _____ Religion/Spiritual Practice: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Telephone Numbers: Day_____ Evening: _____ Cell: _____

CURRENT SITUATION

Relationship Status: _____

What sort of work are you doing now? _____

Does your present work satisfy you? _____

If no, please explain: _____

_____

With whom do you live? _____

_____

Any problems in your home/living environment? _____

_____

_____

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PERSONAL AND SOCIAL HISTORY

Father: Name: _____ Age: _____

Occupation: _____ Health: _____

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

Cause of death: _____

Mother: Name: _____ Age: _____

Occupation: _____ Health: _____

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

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): _____

_____

_____

_____

_____

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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 children. _____

_____

_____

_____

_____

_____

Any issues with addiction in your family: _____

_____

Were you able to confide in your parents? _____

Basically, did you feel loved and respected by your parents? _____

If you have/had a stepparent, give your age when your parent remarried: _____

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Has anyone (parents, relatives, friends) ever interfered in your marriage, occupation, etc? _____

If yes, please describe:_____ _____

_____

_____

Have you ever "come out" to others about some aspect of your identity? _____

If yes, what identity and at what age were you out to yourself, family, friends, and/or others?

_____

_____

_____

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
___ Unhappy childhood
___ Emotional/behavior problems
___ Legal trouble
___ Death in the family
___ Medical problems
___ Ignored
___ Not enough friends
___ School problems
___ Financial problems
___ Strong religious convictions
___ Drug use
___ Used alcohol
___ Severely punished
___ Sexually abused
___ Severely bullied/teased
___ Eating disorder
___ Other: _____
_____
_____
_____

Have you ever been hospitalized for mental health reasons? _____

If yes, most recent date and location: _____

Have you ever attempted suicide? _____ If yes, most recent date: _____

Have you ever physically assaulted someone else? _____ If yes, most recent date: _____

Are you concerned about violence in your relationship(s)? _____

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Does any member of your family suffer from an emotional/mental disorder? _____

_____

Has any relative attempted or committed suicide? _____

If yes, what was their relationship to you and your age at the time? _____

_____

Have you been in therapy before? _____

If yes, please include a rough idea of the length of time and what was / wasn't helpful about it:

_____

_____

DESCRIPTION OF PRESENTING PROBLEMS

Please 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? _____

_____

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What seems to worsen your problems? _____

_____

What have you tried that has **not** been helpful? _____

_____

What have you tried that **has** been helpful? _____

_____

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

Not at all satisfied [----------] Very satisfied

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

Relaxed [----------] 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? _____

_____

_____

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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 Interpersonal Relationships, Behaviors, Feelings, Physical Sensations, Images, Thoughts, and Biological Factors.

INTERPERSONAL RELATIONSHIPS

Friendships

Do you make friends easily? _____ Do you keep them? _____

Did you date much during high school? _____ College? _____

Were you ever bullied or severely teased? _____

Describe any relationship that gives you:

Joy: _____

_____

Grief: _____

_____

Rate the degree to which you generally feel relaxed and comfortable in social situations:

Very Relaxed [----------] Very Tense

Marriage/Committed Relationship(s)

How long did you know your partner before your engagement/commitment? _____

If married, how long were you engaged before your marriage? _____

How long have you been married / in a committed relationship? _____

What is your partner's age? _____ Partner's occupation? _____

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Describe your partner's personality: _____

_____

_____

_____

What do you like most about your partner? _____

_____

_____

_____

What do you like least about your partner? _____

_____

_____

_____

What factors detract from your relationship satisfaction? _____

_____

_____

_____

Please indicate how satisfied you are with this partnership/marriage:

Very dissatisfied [----------] Very satisfied

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

Very poorly [----------] Very well

How many children do you have? _____

Please give their names and ages: _____

_____

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_____

Do any of your children present special problems? _____

If yes, please describe: _____

_____

Do you have additional partners that this form did not provide space for? _____

_____

_____

Any significant details about a previous marriage/relationship? _____

_____

_____

Sexual Relationships

Describe your parents' attitude toward sex. Was sex discussed in your home? _____

_____

When and how did you derive your first knowledge of sex? _____

_____

When did you first become aware of your own sexual impulses? _____

_____

Have you ever experienced any anxiety or guilt arising out of sex or masturbation? _____

If yes, please explain: _____

_____

Any relevant details regarding your first or subsequent sexual experiences? _____

_____

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_____

Is your present sex life satisfactory? _____

If no, please explain: _____

_____

_____

Please note any sexual concerns not discussed above: _____

_____

_____

Other Relationships

Are there any problems in your relationships with people at work? _____

If yes, please describe: _____

_____

_____

Please complete the following:

One of the ways people hurt me is: _____

I could shock you by: _____

My partner would describe me as: _____

My best friend thinks I am: _____

People who dislike me: _____

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Are you currently troubled by any past rejections or loss of a love relationship? _____

If yes, please explain: _____

_____

_____

BEHAVIORS

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

__ Over eat	__ Loss of control	__ Eating problems	__ Compulsions
__ Take drugs	__ Suicide attempts	__ Phobic avoidance	__ Crying
__ Unassertive	__ Self-injury	__ Spend too much money	__ Outbursts of anger
__ Odd behavior	__ Smoking	__ Can't keep a job	__ Others: _____
__ Drink too much	__ Withdrawal	__ Take too many risks	_____
__ Work too hard	__ Nervous Tics	__ Aggressive behavior	_____
__ Procrastination	__ Sleep disturbance	__ Impulsive reactions	
__ Lazy	__ Insomnia	__ Concentration difficulties	

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

_____

What would you like to start doing? _____

_____

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? _____

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If yes, please explain: _____

_____

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? _____

_____

_____

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PHYSICAL SENSATIONS

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

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

What sensations are:

Pleasant for you? _____

Unpleasant for you? _____

IMAGES

Check any of the following that apply to you:

I picture myself:

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

I have:

__ Pleasant sexual images
__ Unpleasant childhood images
__ Negative body image
__ Unpleasant sexual images
__ Lonely images
__ Seduction images
__ Images of being loved
__ Others: _____
_____
_____

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

_____

_____

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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	__Confused	__ Morally degenerate	__ Lazy
__ Confident	__ Useless	__ Ugly	__ Horrible thoughts	__ Honest
__ Worthwhile	__ Evil	__ Stupid	__ Concentration difficulties	__Dishonest
__ Ambitious	__ Crazy	__ Naïve	__ Memory problems	__Others:
__ Sensitive	__ Considerate	__ Incompetent	__ Can't make decisions	_____
__ Loyal	__ Deviant	__ Conflicted	__ Suicidal ideas	_____
__ Trustworthy	__ Unattractive	__ Attractive	__ Good sense of humor	_____
__ Full of regrets	__ Unlovable	__ Persevering	__ Hard working	_____
__Worthless	__ Inadequate	__ Undesirable	__ Untrustworthy	

What would you consider to be your craziest thought or idea? _____

_____

Are you bothered by thoughts that occur over and over again? _____

If yes, what are these thoughts? _____

_____

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

_____

How strongly do you agree with each of the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I should not make mistakes.	[				]
I should be good at everything I do	[				]
When I do not know something, I should pretend that I do.	[				]
I should not disclose personal information.	[				]
I am a victim of circumstances.	[				]
My life is controlled by outside forces.	[				]
Other people are happier than I am.	[				]
It is very important to please other people.	[				]
Play it safe; don't take any risks.	[				]
I don't deserve to be happy.	[				]
If I ignore my problems, they will disappear.	[				]
It is my responsibility to make other people happy.	[				]
I should strive for perfection.	[				]
There are two ways of doing things: the right way and the wrong way.	[				]
I should never be upset.	[				]

BIOLOGICAL FACTORS

Do you have any concerns about your physical health? _____

If yes, please specify? _____

_____

_____

Please list any medications you are currently taking: _____

_____

_____

Do you eat three well-balanced meals each day? _____

Do you get regular physical exercise? _____

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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

Age at first period: _____ Were you informed? _____ Did it come as a shock? _____

Are you regular? _____ Duration: _____ Do you have pain? _____

Do your periods affect your moods? _____ Date of last period: _____

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Check any of the following that apply to you:

	Never	Rarely	Occasionally	Frequently	Daily
Muscle Weakness					
Diarrhea					
Constipation					
Gas					
Indigestion					
Nausea					
Vomiting					
Heartburn					
Dizziness					
Palpitations					
Fatigue					
Allergies					
High blood pressure					
Chest pain					
Shortness of breath					
Insomnia					
Sleep too much					
Fitful sleep					
Early morning awakening					
Earaches					
Headaches					
Backaches					
Bruise or bleed easily					
Weight problems					
Tranquilizers					
Diuretics					
Diet Pills					
Marijuana					
Hormones					
Sleeping Pills					
Aspirin					
Cocaine					
Pain Killers					
Narcotics					
Stimulants					
Hallucinogens (e.g. LSD)					
Laxatives					
Cigarettes					
Alcohol					
Birth Control Pills					
Vitamins					
Under eat					
Over eat					
Eat junk food					
Other					

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Please describe any significant childhood (or other) memories and experiences that you think your therapist should be aware of: