Capitol Pain Institute
Kimberly G. Schocket, PhD

Health Inventory

A. Personal Information

Name: _____ Date: _____

Relationship Status: _____ Committed Relationship _____ Single _____ Married

_____ Separated/Divorced _____ Domestic Partnership _____ Widowed

Do you have children? _____ Yes _____ No

If yes, what are their names & ages? _____

Ethnic Racial Identity: _____ African American _____ Asian American (please specify):

_____ Caucasian _____ Biracial (please specify):

_____ Latina/Latino _____ Native American

_____ Other

Employer: _____ Occupation: _____

How Many Years with this Employer: _____

If you are a student, what school do you attend? _____

B. Clinical Information

Where is your pain located? _____

How long has your pain been present? _____

Procedures and treatments you have tried in past to alleviate pain? _____

_____

Please list current or chronic health problems: _____
_____

Please list current medications (prescribed & over-the-counter):
_____
_____

In the space below, please briefly describe your reason(s) for seeking services:
_____
_____

Have you ever had previous counseling or psychotherapy? _____ Yes _____ No

If "yes", by whom, when, and for what? _____

Have you ever been psychiatrically hospitalized? _____ Yes _____ No

Have you ever made a suicide attempt/gesture? _____ Yes _____ No

PLEASE USE THE SCALE BELOW TO INDICATE YOUR CURRENT LEVEL OF DISTRESS ON THE FOLLOWING ITEMS:

	No concern	Minimal		Moderate		Urgent
Academic/Occupational concerns	0	1	2	3	4	5
Perfectionism	0	1	2	3	4	5
Financial Concerns	0	1	2	3	4	5
Relationship with family or friends	0	1	2	3	4	5
Relationship with romantic partner	0	1	2	3	4	5
Sexual orientation concerns	0	1	2	3	4	5
Racial/cultural issues or conflict	0	1	2	3	4	5

Recent loss or death	0	1	2	3	4	5
Loneliness	0	1	2	3	4	5
Low self-esteem, self-confidence	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Anxiety, fears, worries	0	1	2	3	4	5
Irritability, anger	0	1	2	3	4	5
Sleep problems	0	1	2	3	4	5
Eating problems	0	1	2	3	4	5
Body image concerns	0	1	2	3	4	5
Sexual concerns	0	1	2	3	4	5
Survivor of abuse (Emotional, physical, or sexual)	0	1	2	3	4	5
Post-partum concerns	0	1	2	3	4	5
Problems with alcohol or drugs	0	1	2	3	4	5
Other addictive concerns	0	1	2	3	4	5
Cutting/self-injurious behavior	0	1	2	3	4	5
Suicidal thoughts/behaviors	0	1	2	3	4	5
Fear of endangering others	0	1	2	3	4	5

Please indicate how often you use the following substances

Alcohol: ____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

Nicotine: ____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

Recreational Drugs: ____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

Thank you for completing the paperwork. Data is solely used for the purpose of understanding treatment concerns and will be held strictly confidential.