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**Psychosocial Questionnaire**

This questionnaire is designed to help you provide information about your history and present life situation. Its purpose is to assist in the comprehensive assessment for which you have been scheduled. It will remain as part of your confidential file at the St. Louis Consultation Center. This information will be included in the comprehensive report and feedback session. We encourage you to be as thorough as possible as you complete this form.

Please answer the questions in the space provided. Feel free to use both sides of each sheet or add additional sheets if necessary. We understand that this questionnaire includes sensitive information and appreciate your cooperation.

**SECTION I: BASIC INFORMATION**

Name:

Address in St. Louis area:

Permanent address (if different):

Telephone in St. Louis area:

Permanent Telephone: Work:      Home:      Cell:

Place of Work:

Occupation/Ministry:

Race/Ethnic Background:

Age:

Date of Birth:

Height:

Weight:

Major Superior or Ordinary:

Contact Person (if different):

Diocese/Community:

Address:

Telephone:

How did you or your referring superior learn of the St. Louis Consultation Center?

On a scale of 1 through 5 (1 is lowest, 5 is best),

how would you rate your current level of well-being?

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| **SECTION II: THE PROBLEM**1. Describe in your own words why you are seeking or have been referred for evaluation. |       |
| 2. When did this problem begin? |  |
| 3. What led to the referral for this evaluation?4. Have you shared the concerns which led to this assessment with anyone? If so, with whom? |            |
| 5. Have you been in psychiatric and/or psychological treatment for this problem or for any other problem in the past? Please provide details of any previous treatment. |       |
| 6. What would you like to achieve as a result of the evaluation process? |       |

**SECTION III: HEALTH HISTORY**

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| 1. List all medication which you currently take on a regular basis. |       |
| 2. List all surgeries which you have had, including dates and reasons for the operation. Werethere any complications? |       |
| 3. List any history of serious illness or any ongoing chronic illnesses or conditions for which you are currently being treated.4. List commonly recurring or chronic symptoms from which you currently suffer.  |            |
| 5. Please provide the names of your current physician(s) and/or psychiatrist, including telephone numbers. |       |
| 6. When was your last physical examination? What were the results as you understood them? |       |

**SECTION IV: FAMILY HISTORY**

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| 1. Were you raised by your biological parents? If not, by whom? Were there others who helped raise you? |       |
| 2. Did any members of your extended family live with you during your childhood or adolescence? When did this occur and what was this experience like for you? |       |
| 3. Did your family relocate? If so, what was this experience like for you? |       |
| 4. Are your parents still living? If not, when and how did they die? How has this impacted you? |       |
| 5. Is there any family history of emotional struggles? Was any family member diagnosed with a psychiatric disorder? How was this handled in your family? |       |
| 6. Is there any history of physical, emotional, or sexual abuse or neglect in your family? |       |
| 7. Have you ever been a victim of physical, emotional or sexual abuse in or outside of your family? |       |
|  8. If one or both of your parents worked outside the home, please describe their occupations. |       |
| 9. What was the nature of discipline in your home? |       |
| 10. Did either of your parents abuse alcohol or any other drug? |       |
| 11. Please list your siblings and their place in the birth order? Are they still living? If not, when and how did they die? How has this impacted you? |       |
| 12. Have your siblings had any major life problems (e.g., emotional issues, drug addiction, alcoholism, etc.)? |       |
| 13. Briefly describe your childhood. |       |
| 14. Describe your parents' relationship with each other and their relationships with you. |       |
| 15. During your childhood, what was unique about you? What is your perception of how your family would have described you? |       |
| 16. Please describe your current relationships with parents and siblings.  |       |

**SECTION V: SOCIAL, SEXUAL, AND DATING HISTORY**

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| --- | --- |
| 1. Describe your social relations with peers and teachers in elementary and high school. |       |
| 2. Describe your dating experience, if any. When did you begin dating? How would you describe the experience? |       |
| 3. When and how did you learn about sex? How comfortable was your family with this subject? |       |
| 4. How comfortable are you in dealing with sexual issues? |       |
| 5. What are your current sources of social support? How helpful are these to you?  |       |
| 6. How successful do you feel in developing and maintaining close relationships in your life? |       |
| 7. Are there persons in your immediate or general community or social circle who make your life especially difficult? |       |
| 8. What have been the benefits, difficulties, and/or challenges of living a celibate lifestyle? |       |
| 9. How long have you known your closest friend? |       |
| 10. Have you ever been harassed or bullied? If yes, please explain how old you were, what happened, and how this affected you. |       |
|  |  |

**SECTION VI: DESCRIPTIONS OF SELF**

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| --- | --- |
| 1. Describe yourself, including five adjectives that best describe you. |       |
| 2. What is the source of your greatest happiness? |  |
| 3. What is the source of your greatest unhappiness? |       |
| 4. What do you see as your principal strengths?  |       |
| 5. What do you see as your principal shortcomings? |       |
| 6. What would you describe as your most significant accomplishments in life thus far? |       |
| 7. What would you identify as your most frustrating experience in life so far? |       |
| 8. Is there anything about yourself or your history that would be helpful for us to know, matters which would not be obvious to a casual acquaintance or even to a moderately good friend? |       |
| 9. How do you spend time outside of work?  |       |
| 10. How would you like to be spending free time? |       |

**SECTION VII: SELF-CARE**

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| --- | --- |
| 1. Do you engage in any regular form of exercise? Describe. |       |
| 2. Describe your patterns of sleep. |       |
| 3. Describe your eating habits.4. Do you use tobacco products? Have you in the past? |            |
| 5. Have you even been in legal trouble? If so, describe. |       |
| 6. Do you have a support network of people with whom you can share your struggles & concerns on an ongoing basis? Do you reach out to them when needed? |       |
| 7. Do you have close friends among the presbyterate of your diocese/religious congregation?8. Have you experienced any significant losses or sources of grief? If so, please describe. |            |
| 9. Do you think you have the skills to deal with inter-personal conflicts when they arise? |       |
| 10. How do you deal with feelings of anger? |       |
| 11. Are you a part of any twelve-step fellowship? (AA, GA, SA, NA, etc.) |       |
|  a. If yes, do you have a sponsor with whom you are in  regular contact? |       |

**SECTION VIII: SYMPTOM CHECKLIST**

The following are common symptoms that people have when they suffer from various forms of disorders. Some of the symptoms are repetitious because they are grouped under different possible clusters. Please respond to all of the questions, and if you answer “yes” to any of the questions, please describe.

## Depressive Disorders

|  |  |
| --- | --- |
| 1. How would you describe your mood lately? | Stable [ ]  Variable [ ]  Mostly depressed [ ] Mostly anxious [ ]  Always depressed or anxious [ ]  |
| 2. How would you rate your energy level? | Good [ ]  Less than usual [ ]  Fatigued [ ]  |
| 3. Do you continue to experience pleasure in your life and interest in your normal activities? If not, please describe. |        |
| 4. Has your weight changed significantly (10 pounds or more) within the past year? |        |
|  a. Within the past month? |       |
| 5. Is your sleep disturbed? If yes, please explain how.  |       |
| 6. Are you sleeping more than usual (more than eight or nine hours each day?) |       |
| 7. Have you ever had periods where you did not require much sleep? If yes, how long did you go without sleeping? |       |
| 8. Do you have a difficult time settling down or relaxing? |       |
| 9. Do you experience feelings of worthlessness or guilt? |       |
| 10. Do you have difficulty concentrating/reading? |       |
| 11. Do you find yourself sad or easily moved to tears? |       |
| 12. Do you find yourself angry or irritable? |       |
| 13. Have you had recurrent thoughts of death or dying? |       |
| 14. Have you had suicidal thoughts? |       |
|  a. If yes, have you thought of how you might do it?  |       |
| 15. Have you ever had thoughts of harming yourself or of causing yourself physical pain?  |       |
|  a. If yes, have you ever engaged in self-injurious acts (cutting, burning, etc)? If yes, please specify the behavior. |       |
|  b. If yes, did you receive medical attention for injuries? |       |
|  c. If yes, when did you last engage in such behavior?  |       |
| 16. If you believe you are depressed, how long have you felt this way? | A few days [ ]  Two weeks [ ]  Six months [ ]  More than six months [ ]   |
| 17. Are you currently grieving or mourning any losses?18. Is there anything else about your mood that concerns you (e.g., racing thoughts? mood swings? feeling out of control?) |            |

## Panic

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| 1. Have you had any of the following symptoms within the past six months? |
|  a. Palpitations, pounding heart, or accelerated heart rate? |       |
|  b. Sweating without sustained physical activity  |       |
|  c. Trembling/shaking |       |
|  d. Sensations of shortness of breath or smothering |       |
|  e. Feeling of choking |       |
|  f. Chest pain or discomfort |       |
|  g. Nausea or abdominal distress |       |
|  h. Feeling dizzy, unsteady, lightheaded, or faint  |       |
|  i. Feelings of unreality or feeling detached from self |       |
|  j. Fear of losing control or going crazy |       |
|  k. Fear of dying |       |
|  l. Numbness or tingling sensations, especially in your hands or feet |       |
|  m. Chills or hot flashes |       |
| 2. If yes to any of these symptoms, did you seek medical consultation? If yes, what were the results as you understoodthem? |       |

## OCD

|  |  |
| --- | --- |
| 1. Have you had recurrent or persistent thoughts, impulses or images that seem inappropriate to you and that cause you anxiety? |       |
|  a. If yes, do you try to suppress these in any way? |       |
| 2. Do you engage in any repetitive behavior, such as hand washing or checking, that you feel driven to perform? If yes, please specify the behavior: |       |
| 3. Do you engage in mental acts, such as counting or repeating words silently, that you feel driven to perform? If yes, please specify the behavior |       |
| 4. If you have such behaviors, do you recognize them as irrational? |       |

## PTSD

|  |  |
| --- | --- |
| 1. Have you been exposed to an event in which you have felt seriously threatened and to which your response was to feel intense fear, helplessness, or horror?  |        |
|  a. If yes, please specify what and when it happened. |       |
| 2. Do you have disturbing memories of such an event? |       |
| 3. Do you have distressing dreams or nightmares about frightening things? |       |
| 4. Do you sometimes feel that past traumatic events were recurring in the present? |       |
| 5. Do you sometimes get lost in a daydream thinking about some disturbing event? |       |
| 6. Do you avoid talking about certain aspects of your life that you find distasteful? (These might include your family life, unhappy experiences, traumatic experiences you have had.) |       |
| 7. Do you sometimes feel detached or estranged from others for no apparent reason? |       |
| 8. Do you have a difficult time experiencing your feelings? |       |
| 9. Do you have a sense that life is short? |       |
| 10. Do you have difficulty falling or staying asleep? |       |
| 11. Are you irritable or given to outbursts of anger? |       |
| 12. Do you have trouble concentrating? |       |
| 13. Are you watchful of others and/or mistrustful? |       |
| 14. Do you startle easily? |       |
| 15. Are there any other thoughts, memories, or dreams you have that concern you? If so, please describe: |       |

## GAD

|  |  |
| --- | --- |
| 1. Do you worry excessively? |       |
| 2. Do you find worry difficult to control? |       |
| 3. Have you had any of the following symptoms? |       |
|  a. Restlessness or feeling keyed up or on edge |       |
|  b. Being easily fatigued  |       |
|  c. Difficulty concentrating or mind going blank  |       |
|  d. Irritability |       |
|  e. Muscle tension  |       |
|  f. Sleep disturbance (difficulty falling asleep or staying asleep or restless unsatisfying sleep) |       |

## Alcohol/Drug Use

|  |  |
| --- | --- |
| 1. Do you drink alcoholic beverages? |       |
|  a. If yes, how much and how often do you drink alcohol? |       |
| 2. Did anyone in your family of origin abuse alcohol or drink problematically? |       |
| 3. Have you ever felt that you should cut down on your drinking? |       |
| 4. Have people ever angered or annoyed you by criticizing your drinking? |       |
| 5. Have you ever felt bad or guilty about your drinking? |       |
| 6. Have you ever taken a drink to calm your nerves in the morning? |       |
| 7. Have you ever not remembered something that occurred when you were drinking? |       |
| 8. Have you ever gotten drunk when you did not intend to do so? |       |
| 9. Do you drink alcohol on a daily basis? |       |
| 10. Does your use of alcohol prevent you from pursuing other forms of recreation, relaxation or other relationships? |       |
| 11. Have you ever used any illegal substance for the purpose of altering your consciousness? |       |
| 12. Have you ever used prescription medicine in a manner inconsistent with the prescription of your physician? |       |
| 13. Have you ever collected more than one prescription from different physicians so as to procure a supply? |       |

### Sexual Addiction/Compulsivity

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| --- | --- |
| 1. Do you regularly purchase sexually explicit magazines or videos? |       |
| 2. Do you now or have you viewed sexually explicit material on the Internet? |       |
| 3. Have you done this on more than an occasional basis?  |       |
| 4. Have you ever been involved in sexually active relationships that were inconsistent with your celibate promise/vow of chastity? |       |
| 5. Has anyone ever complained about your sexual behavior? |       |
| 6. Do you have trouble stopping or restraining your sexual behavior? |       |
| 7. Have you felt remorse about your sexual behavior? |   |
| 8. Has your sexual behavior ever created problems for you, your family, or members of your community? |       |
| 9. Have you ever sought help for sexual difficulties? |       |
| 10. Have you ever worried that others would find out about your sexual behavior? |       |
| 11. Has anyone been hurt by your sexual behavior? |       |
| 12. Have you ever participated in sexual activity in exchange for money or gifts? |       |
| 13. Have you had periods of sexual abstinence interspersed with periods of sexual activity? |       |
| 14. Have you tried to stop sexual activity and failed? |       |
| 15. Do you hide your sexual behavior from others? |       |
| 16. Have you had multiple sexual partners during the same time period? |       |
| 17. Have you ever felt degraded by your sexual behavior? |       |
| 18. Have sexual or romantic fantasies been a way for you to escape stress or conflict in your life? |       |
| 19. Have you ever felt depressed after a sexual incident? |       |
| 20. Have you ever engaged in sadomasochistic behavior? |       |
| 21. Has your sexual activity interfered with your life or ministry? |       |
| 22. Have you been sexual with minors? |       |
| 23. Do you feel controlled by your sexual desire or fantasies of romance? |       |
| 24. Do you ever think your sexual desire is stronger than you are? |       |
| 25. Has masturbation been problematic in your life? |       |
| 26. Have you ever met a person online and arranged to meet for the purpose of sexual activity? |       |
| 27. Have you ever gone to a bar to pick up person for the purpose of sexual activity? |       |
| 28. Have you ever 'cruised' a park, rest stop, or other venue for the purpose of sexual activity? |       |
| 29. Have you ever had physical/ sexual contact with a person whom you were counseling or with a member of your parish? |       |

## Eating

|  |  |
| --- | --- |
| 1. Do you eat when you are not hungry? |       |
| 2. Do you go on 'eating binges' for no apparent reason? |       |
| 3. Do you spend a significant amount of time thinking about food? |       |
| 4. Do you have feelings of guilt and/or remorse after overeating? |       |
| 5. Do you prefer to eat alone? |       |
| 6. Do you eat secretly? |       |
| 7. Do you make a point of eating sensibly in the presence of others, only to overeat when you are alone?  |       |
| 8. Do you hoard or hide food?  |       |
| 9. Have you tried to diet for a few days and then abandoned it as hopeless?  |       |
| 10. Do you resent others' commenting on your weight or eating? |       |
| 11. Do you eat to provide a sense of emotional comfort to yourself? |       |
| 12. Does your eating or your weight make you unhappy? |       |
| 13. Do you suffer from medical ailments that are attributable to or exacerbated by excess weight or overeating? |       |

## Gambling

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| --- | --- |
| 1. Have you ever lost time from work or school due to gambling? |       |
| 2. Has gambling ever made your home or community life unhappy?  |       |
| 3. Does gambling affect your reputation?  |       |
|  |       |
|  4. Have you ever gambled to get money to pay debts or otherwise solve financial difficulties? |       |
| 5. Has gambling caused a decrease in your ambition or efficiency?  |       |
| 6. After losing money, have you ever felt you must return to gambling as soon as possible and win back your losses?  |       |
| 7. After a win have you ever had a strong urge to return and win more?  |       |
| 8. Have you often gambled until your last dollar was gone?  |       |
| 9. Have you ever borrowed to finance your gambling?  |       |
| 10. Have you ever sold anything to finance gambling?  |       |
| 11. Have you ever been reluctant to use 'gambling money' for normal expenditures?  |       |
| 12. Has gambling made you careless of your welfare?  |       |
| 13. Have you ever gambled longer than you planned? |       |
| 14. Have you ever gambled to escape worry or trouble? |       |
| 15. Have you ever committed, or considered committing, an illegal act to finance gambling? |       |
| 16. Has gambling caused you to have difficulty sleeping? |       |
| 17. Do arguments, disappointments, or frustrations create within you an urge to gamble? |       |
| 18. Have you ever had an urge to celebrate good fortune by a few hours of gambling? |       |
| 19. Have you ever considered self-destruction or suicide as a result of your gambling? |       |

### Money Management/Spending

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| --- | --- |
| 1. Are you living within the means set by your community or expected as a person in ministry? |       |
| 2. Are you responsible for parish/community funds?  |       |
| 3. Have you ever misspent such funds?  |       |
| 4. Have you ever bought things you did not need?  |       |
| 5. Have you felt that your spending habits were out of control?  |       |
| 6. Do you have feelings of shame/embarrassment about your spending?  |       |
| 7. Have you ever shuffled funds from one account to another to mask your actual spending?  |       |

## Miscellaneous

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| 1. Do you engage in any other kinds of behavior, such as exercise, hoarding or collecting things, which might be described as addictive or compulsive or which other people have commented upon? |       |

**SECTION IX: EDUCATION**

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| 1. Please list any advanced degrees which you hold, the nature of your studies and the dates and institutions from which they were granted. |       |
| 2. Please describe other training or CPE experience. |       |

**SECTION X: OCCUPATIONAL HISTORY**

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| --- | --- |
| 1. List in chronological order your work/ministry history. Include dates and reasons for changing. |       |
|  2. What is your current position? How long have you held  it? How satisfied are you with it? What are the most satisfying aspects of it and the most frustrating? |       |
|  3. How do you get along with your colleagues at work? |       |
|  4. How do you get along with your supervisors/superiors? |       |
|  5. How do you get along with those you supervise or employ? |       |
| 6. What would you like to be doing occupationally in ten years? |       |

**SECTION XI: OTHER MINISTRY**

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| --- | --- |
| 1. Describe your involvement in the local civic community. Do you belong to any social clubs ororganizations?  |       |
| 2. Describe involvement in any diocesan, state or national church organization. |       |
| 3. What causes or movements within the Church or independent of it are most dear to you?  |       |
| 4. Have you ministered abroad?  |       |
| If you have ministered abroad, have you undergone a re-entry program to prepare you for re-entering American culture?  |       |

**SECTION XII: FORMATION**

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| 1. What kind of elementary did you attend (parochial, public, private)?  |       |
| 2. What kind of high school did you attend? |       |
| 3. If you attended a minor seminary, how was that experience for you? |       |
| 4. If you attended seminary, when and where was that and what was the experience like for you?  |       |
| 5. If you participated in a novitiate program, please describe what it was like for you.  |       |
| 6. Were your studies shortened or accelerated for any reason? Please explain.  |       |
| 7. If you studied theology, where and when did you do so? Was there any interruption of your studies? |       |
| 8. If you are ordained: when, where and by whom were you ordained? |       |
| 9. If you are professed, when was it? |       |
| 10. Describe your experience of the formation process. |       |