



Name: _____ Date: ____/____/____
Last First MI

Address: _____
Street City State Zip

Home Phone: (____) - ____ - ____ Work Phone: (____) - ____ - ____

Check if okay to leave a message at: Home ___ Work ___ Cell ___ Email ___ Other _____

Employer: _____ Occupation: _____

Date of Birth: ____/____/____ Male ___ Female ___

Level of education: HS ___ College ___ Graduate Degree ___ Other: _____

Marital Status: _____ Years Married: Present marriage ___ Previous marriage(s) ___

Name of Spouse: _____ Date of Birth: ____/____/____

| Children's Names | Sex | Age |
|------------------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Emergency Contact Person: _____

Phone: (____) - ____ - ____ Relationship: _____

If client is a minor, client resides with: Mother ___ Father ___ Both ___ Other _____

Referred by (optional): _____

If referred by a doctor, may we have permission to contact that doctor? Yes ___ No ___

Name: _____

Address: _____ Phone: (____) - ____ - ____

What hobbies, if any, do you have? _____

What do you do for recreation, physical activity? _____

Do you smoke? Yes ___ No ___ If yes, how much/day? _____

How would you rate your current physical health? Excellent ___ Good ___ Fair ___ Poor ___

Are you currently experiencing any physical problems? Yes ___ No ___ If yes, please explain: _____

Date of last physical examination: ____/____/____

Previous hospitalizations:

Date: ____/____/____ Reason: _____ Date: ____/____/____ Reason: _____

Have you ever been an inpatient for mental health reasons? Yes ___ No ___ Approx. dates _____

Are you currently suicidal? Yes ___ No ___ Suicidal thoughts only? Yes ___ No ___

Previous suicide attempts? Yes ___ No ___ Any aggressive/violent thoughts or acts? Yes ___ No ___

Any past aggressive/violent thoughts or acts? Yes ___ No ___

Family Physician's Name: _____ Phone: (____) - ____ - ____

If you are taking any medications, please list:

| Medication(s) – Prescription and Over the Counter | Dosage | Prescribed for |
|---|--------|----------------|
| | | |
| | | |
| | | |
| | | |

Please check all that apply

| Current | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Depressed mood |
| <input type="checkbox"/> | <input type="checkbox"/> | Daily irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | No interest/pleasure in activities |
| <input type="checkbox"/> | <input type="checkbox"/> | Increase/decrease of appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty sleeping/poor sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Increase/decrease need for sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty concentrating |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty making decisions |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue or loss of energy |
| <input type="checkbox"/> | <input type="checkbox"/> | Feelings of worthlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Feelings of hopelessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent thoughts of death |
| <input type="checkbox"/> | <input type="checkbox"/> | Racing thoughts or ideas |
| <input type="checkbox"/> | <input type="checkbox"/> | Rapid mood swings |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath/dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Sweating/feeling flushed |
| <input type="checkbox"/> | <input type="checkbox"/> | Choking |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or abdominal distress |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling unreal |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness or tingling sensations |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear of dying |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual orientation issues |
| <input type="checkbox"/> | <input type="checkbox"/> | Accelerated heart rate or chest pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent & persistent thoughts/behaviors |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty controlling anger/bad temper |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological abuse (emotional/verbal) |

| Current | Past | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty controlling anger/bad temper |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological abuse (emotional/verbal) |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Distressing memories that reoccur |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent distressing dreams |
| <input type="checkbox"/> | <input type="checkbox"/> | Delusions (unreasonable thoughts/beliefs) |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you hear or see things that others don't? |
| <input type="checkbox"/> | <input type="checkbox"/> | Not able to control impulse to steal |
| <input type="checkbox"/> | <input type="checkbox"/> | Preoccupation with/or frequent gambling |
| <input type="checkbox"/> | <input type="checkbox"/> | Sense of reliving traumatic events |
| <input type="checkbox"/> | <input type="checkbox"/> | Periods of time you cannot remember |
| <input type="checkbox"/> | <input type="checkbox"/> | Intense reactions to certain events/anniversaries |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoidance of thoughts or feelings of trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoidance of activities or situations of trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | Detachment from feelings, people, places |
| <input type="checkbox"/> | <input type="checkbox"/> | Binging/compulsive overeating |
| <input type="checkbox"/> | <input type="checkbox"/> | Intentional vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Laxative or diuretic use |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive dieting |
| <input type="checkbox"/> | <input type="checkbox"/> | Compulsive exercising |
| <input type="checkbox"/> | <input type="checkbox"/> | Compulsive sexual behaviors |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear of going crazy |

Substances Used/Abused

| Current | Past | |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cocaine |
| <input type="checkbox"/> | <input type="checkbox"/> | Marijuana |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Ecstasy |
| <input type="checkbox"/> | <input type="checkbox"/> | Amphetamines |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |

| Current | Past | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prescription (Rx) |
| <input type="checkbox"/> | <input type="checkbox"/> | OTC Medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Opiates |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

| Current | Past | |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cocaine |
| <input type="checkbox"/> | <input type="checkbox"/> | Marijuana |
| <input type="checkbox"/> | <input type="checkbox"/> | Narcotics |
| <input type="checkbox"/> | <input type="checkbox"/> | Ecstasy |
| <input type="checkbox"/> | <input type="checkbox"/> | Amphetamines |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol |

| Current | Past | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prescription (Rx) |
| <input type="checkbox"/> | <input type="checkbox"/> | OTC Medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Opiates |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Briefly, what difficulties or problems have brought you to seek help at this time? _____

When did these problem(s) begin? _____

On a scale of 1-10, rate your current level of distress: _____

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Have you been to counseling before? Yes ___ No ___ If yes, from _____ to _____

With whom and what was the nature of the counseling? _____

Have you consulted with a minister or pastor? Yes ___ No ___ If yes, from _____ to _____

With whom and what was the nature of the consultation? _____

Do you attend a church or other place of worship? Yes ___ No ___ If so, how often? _____

Where? _____

Briefly describe your view of your relationship with God: _____

Signature

Date