Patient Name: Last _____First _____ Middle _____ Birth date: ___/____/_____

Please describe the problem(s) that you want help with: _____

_____

How has this problem affected your life in the following areas?

1. Family _____
2. Work _____
3. Social _____
4. Recreational _____
5. Health _____
6. Spiritually _____

How long have you had this problem? _____

Please list any important events in your life that may relate to this problem:

_____

_____

_____

How serious is this problem? mildly moderately very extremely totally

What have you tried to do to solve this problem? _____

_____

What has been successful? _____

_____

Have you had counseling/therapy in the past? Yes No

If so, Counselor Name? _____ When? _____ Focus?_____

What was helpful about the counseling?_____

What was not helpful about the counseling? _____

MARITAL STATUS: Single □ Married □ Divorced □ How Long? _____

- □ Previously married -- How many times? _____
- □ Living with someone -- How long? _____
- □ Separated -- How long? _____
- □ Widowed -- How long? _____

FAMILY HISTORY:

Who raised you? _____

If there were changes, please list and indicate the age you were when these changes occurred:

_____

_____

# of siblings _____ # brothers _____ # sisters _____

In rank order from oldest to youngest, what is your place in the order? _____

Which members of your family are you close to? _____

Are there any family members who are a problem for you? _____

Please indicate other people in your life that provide support for you: _____

_____

Choose five words that best describe your childhood 1._____ 2._____

3. _____ 4. _____ 5. _____

Please check any problems that family members have/have had and indicate relationship:

		Relationship to you
☐	Arrests/convictions _____	_____
☐	Alcoholism _____	_____
☐	Depression _____	_____
☐	Violence _____	_____
☐	Drug Addiction_____	_____
☐	Sexual Abuse_____	_____
☐	Other Addictions_____	_____
☐	Other mental/emotional problems (list below)	
	_____	_____
	_____	_____

Check any of the following that apply to your childhood/adolescence:

☐ Happy childhood	☐ School problems	☐ Medical problems
☐ Unhappy childhood	☐ Family problems	☐ Alcohol use

□ Drug use □ Arrests/convictions □ Low Self Esteem

Victim of:	**Current**	**Past**		**Current**	**Past**
□ Sexual abuse	____	____	□ Physical abuse	_____	_____
□ Domestic violence	____	____	□ Emotional abuse	_____	_____

EDUCATIONAL HISTORY:

Highest Level of Education _____ Course of Study _____

Academic Strengths: _____

_____

Academic Challenges: _____

_____

PHYSICAL AND MENTAL HEALTH:

How would you rate your current health? Very poor 1 2 3 4 5 6 7 8 9 10 Very good

What do you do to take care of yourself physically?_____

List current health problems for which you are receiving treatment: _____

_____

List any medications currently prescribed; include the dosage and reason for taking:

_____

What is your current use of alcohol? _____

Have you had problems with alcohol use in the past? Yes □ No □

If yes, please explain: _____

What is your current use of illegal or other drugs, List? _____

Have you been arrested for alcohol/drug related offenses? Yes □ No □ If yes, when? _____

Have you had treatment for problems with alcohol abuse/dependency? Yes □ No □ If yes, when? _____

Do you have a history of drug use? Yes □ No □

Have you had treatment for drug abuse/dependency? Yes □ No □ If yes, when? _____ Have you ever lost a job/relationship due to the use of alcohol/drugs? Yes □ No □

If yes, please explain:_____

Indicate any of the following that apply to you:

Current	Past	
____	____	Thoughts of suicide
____	____	Plan for suicide
____	____	Suicide attempt
____	____	Hurting yourself deliberately
____	____	Thoughts of hurting someone else

SEVERITY OF PROBLEM: **0=NO PROBLEM 5=DISABLING**	**INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS:**	**EXPLAIN**
0 1 2 3 4 5	Sleep too much	
0 1 2 3 4 5	Sleep too little	
0 1 2 3 4 5	Interrupted sleep	
0 1 2 3 4 5	Other sleep problems	
0 1 2 3 4 5	Memory	
0 1 2 3 4 5	Concentration	
0 1 2 3 4 5	Attention	
0 1 2 3 4 5	Loss of interest in usual activities	
0 1 2 3 4 5	Feelings of sadness	
0 1 2 3 4 5	Loss of energy	
0 1 2 3 4 5	Feeling tired all the time	
0 1 2 3 4 5	Periods of crying	
0 1 2 3 4 5	Feeling of hopelessness	
0 1 2 3 4 5	Loss of sexual desire	
0 1 2 3 4 5	Outbursts of anger	
0 1 2 3 4 5	Change in appetite	
0 1 2 3 4 5	Hearing voices when no person is present	
0 1 2 3 4 5	Unable to recall periods of time in childhood after age 5	
0 1 2 3 4 5	Unable to recall some period of your day	
0 1 2 3 4 5	Walking in sleep	
0 1 2 3 4 5	Nightmares	
0 1 2 3 4 5	Overwhelming fears	
0 1 2 3 4 5	Racing thoughts	
SEVERITY OF PROBLEM: **0=NO PROBLEM 5=DISABLING**	**INDICATE ANY PROBLEMS IN THE FOLLOWING AREAS: EXPLAIN**	
0 1 2 3 4 5	Thoughts of harming someone else	

0 1 2 3 4 5	Thoughts of harming yourself
0 1 2 3 4 5	Thoughts that some person or people are trying to harm you
0 1 2 3 4 5	Feelings of being controlled by forces outside yourself
0 1 2 3 4 5	Feeling compelled to repeat activities for no reason
0 1 2 3 4 5	Unable to relax
0 1 2 3 4 5	Blackouts
0 1 2 3 4 5	Excessive sweating
0 1 2 3 4 5	Death of family members or friends
0 1 2 3 4 5	Panic attacks
0 1 2 3 4 5	Mood swings
0 1 2 3 4 5	Spending sprees
0 1 2 3 4 5	Changes in energy level
0 1 2 3 4 5	Other:

WORK HISTORY:

Usual occupation: _____

Are you currently employed: Yes ☐ No ☐ Length of time: _____

Are you experiencing any financial stressors? If yes, please explain_____

_____

If you have changed jobs during the last five years, give duration of employment and reason for leaving job: _____

_____

Are you happy with your employment situation? Yes No

_____

PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS

Please rate each of the following problem areas that have been present during the past year or those occurring prior to one year if they clearly contribute to the reasons for seeking treatment. Please write in the specific problem:

0=No significant problem 1=Mild or transient problem 2=Moderate 3=severe 4=Extreme 5=Catastrophic N/A=Unknown or cannot categorize

0 1 2 3 4 5 N/A **Problems with primary support group**: Death of a family member, separation, divorce, removal from home, sexual or physical abuse, discord in the family with parents siblings, or other like events. _____

0 1 2 3 4 5 N/A **Problems related to the social environment**: death or loss of a friend, living alone, discrimination, adjustment to life-cycle transitions, such as leaving home or retirement. _____

0 1 2 3 4 5 N/A **Educational problems:** Unable to read, academic problems, discord with teachers or classmates. _____

0 1 2 3 4 5 N/A **Occupational problems:** Unemployment, threat of job loss, stressful work schedule, discord with boss or co-workers. _____

0 1 2 3 4 5 N/A **Housing problems:** Homeless, unsafe neighborhood, discord with neighbors or landlord. _____

0 1 2 3 4 5 N/A **Economic problems:** Not enough money to pay bills, food and rent. _____ _____

0 1 2 3 4 5 N/A **Problems with access to health care services:** Inadequate health care, transportation to health care facilities unavailable, inadequate health insurance. _____ _____

0 1 2 3 4 5 N/A **Problems related to interaction with the legal system/crime:** Arrest, incarceration, litigation, victim of a crime. _____

0 1 2 3 4 5 N/A **Other psychosocial and environmental problems:** Exposure to disasters, discord with non-family caregivers such as counselor, social worker or physician, unavailability of social service agencies. _____ _____

Is there anything else you would like to share to aid in better understanding your situation?

What would you like to gain as a result of counseling?

If you had 3 wishes, what would they be?

1._____

2._____

3._____

Are you receptive to receiving biblical solutions as part of your treatment? Yes □ No □

What is your religious background?_____