The following information is needed to best help you. Please clearly print your response to each question. Case records are strictly confidential.

Section I: Identifying information

Today's date: ___________

Name: _______________________________________

Date of birth: __________________________________

Address: ___________________________ City: ________________ Zip: _________

Home phone: ____________________________ Ok to leave a message? ___________

Work phone: _____________________________ Ok to leave a message? ___________

Emergency Contact: _____________ Relationship: _____________ Phone: _________

Who do you live with?

Name	Age	Relationship to you	Supportive? Y/N
______________________	______	__________________	_______________
______________________	______	__________________	_______________
______________________	______	__________________	_______________
_____________________	______	__________________	_______________
______________________	______	__________________	_______________

Section II: Description of Presenting Problem

Why are you seeking counseling at this time?

____

____

____

____

____

____

____

How long has this been a problem for you?

____

____

____

How would you rate the severity of the problem at this time? (Please place an X on the line below.)

____

Mild Moderate Serious Severe

What symptoms contributed to you coming in today? (Please check all that apply)

Feelings

___ depressed	___ guilty	___ numb	___ other
___ fearful	___ hopeless	___ happy	____________
___ anxious	___ lonely	___ excited	____________
___ distrust	___ sad	___ hopeful	____________
___ helpless	___ stressed	___ inferior	
___ shame	___ unhappy	___ mood shifts	
___ angry	___ out of control		

Thoughts

___ difficulty concentrating	___ unlovable	___ disorganized	___ other
___ worthless	___ confident	___ easily distracted	____________
___ unintelligent	___ worthwhile	___ paranoid	____________
___ unmotivated	___ racing	___ suicidal	
___ unattractive	___ obsessive		

Symptoms/Behaviors

___ overeating
__ procrastinating
___ restless
___ compulsive behaviors
___ taking drugs
___ attempting suicide
___ poor concentration
___ injuring self
___ career/ major decision
___ acting out sexually
___ acting out aggressively
___ recklessness
___ passivity
___drug use
___ sexual problems
___ marital relations
___ parent/child conflicts
___ poor peer relationships
___ worries about body image
___ dating concerns
___ relationship with God
___ impulsive behaviors
___ crying
___ low motivation
___ aggressive behavior
___ outbursts of temper
___ social withdrawal
___ jumpy
___ sleeping too much
___ decreased need for sleep
___ problems with school
___ housing problems
___obsessions
___ drinking alcohol
___ relationship problems
___ financial problems
___ can't turn my mind off
___ other
____
____
____

Physical Symptoms

___ rapid heart rate
___ sweating
___ trembling/ shaking
___ recent weight gain
___ recent weight loss
___ recent appetite changes
___ vomiting
___ shortness of breath
___ muscle tension
___ nightmares
___ chest pain
___ stomach problems
___ fatique/loss of energy
___difficulty falling asleep
___ dizzy or lightheaded
___ difficulty staying asleep
___ pain
___ headaches
___ dry mouth
___ loss of memory
___ other
____
____

Please describe any incidents or problems that might have contributed to this problem (ie, loss of job, breakup of a relationship)

____

____

____

____

____

In the past, how have you dealt with this problem?

____

____

____

____

____

Section III: Medical History

Please describe any medical conditions you have

____

____

____

____

Are you currently taking any medications, including vitamins and supplements?

____

____

____

Have you ever experienced
___ physical abuse ___ emotional abuse ___ sexual abuse or assault

Are you, or is anyone around you, concerned that you have an eating disorder?
___ Y ___ N

How many drinks per day do you consume? __________
Do you smoke? ________________
Do you use recreational drugs? ___________________
How much caffeine do you consume per day? __________________

Have you ever seen a counselor, therapist, psychologist or psychiatrist in the past?
___ Y ___ N
How long ago, and for what reason?

____

____

____

Section IV: Family of Origin Information

	Age	Name	Occupation	Deceased (Y/N)
Mother/Guardian	___	____________	____________	__________
Father/Guardian	___	____________	____________	__________

If applicable

	Age	Name	Occupation	Deceased (Y/N)
Stepmother	___	____________	____________	__________
Stepfather	___	____________	____________	__________
Siblings	___	____________	____________	__________
	___	____________	____________	__________
	___	____________	____________	__________
	___	____________	____________	__________
Children	___	____________	____________	__________
	___	____________	____________	__________
	___	____________	____________	__________
	___	____________	____________	__________

Are your parents divorced? ___ Y ___ N

Have any members of your family had problems with:
Drugs ___ Alcohol ___ Depression ___ Anxiety ___ Other mental illness ___

Problem	Who	Current? (Y/N)
________________	__________	______________
________________	__________	______________
________________	__________	______________

Among your friends and family, whom do you count on for support?

____

____

____

____

Section V: Spiritual Concerns

Are you 100% certain you are going to heaven? __________________________

Why or why not? ____

____

____

____

Briefly describe your current relationship with God ________________________________

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____

____