

Information about Children:

| Name | Age | Living | Yr.Ed | Step-child |
|------|-----|--------|-------|------------|
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Describe relationship to your father _____

Describe relationship to your mother _____

Number of siblings _____

Did you live with anyone other than parents _____

Are your parents living _____ Do they live locally _____

HEALTH

Describe your health _____

Do you have any chronic conditions what _____

List important illnesses and injuries or handicaps _____

Date last medical exam _____ Report _____

Physician's name and address _____

Current medication(s) and dosage _____

Have you ever used drugs for other than medical purposes _____

If yes, please explain _____

Have you ever been arrested _____ Reason _____

Do you drink alcoholic beverages _____ If so, how frequently and how much _____

Do you drink coffee_____How much_____Other caffeine drinks_____

_____How much
Do you smoke_____What_____Frequency_____

Have you ever had interpersonal problems on the job_____

Have you ever had a severe emotional upset_____If yes, explain_____

Have you ever seen a psychiatrist or counselor_____If yes, explain_____

Are you willing to sign a release of information form so that your counselor may write for social, psychiatric, or other medical records_____

SPIRITUAL

Denominational preference_____

Church attending_____Member_____

Church attendance per month (circle) 0 1 2 3 4 5 6 7 8+

Do you believe in God____Do you pray____Would you say you are a Christian_____,
or still in the process of becoming a Christian_____

Have you been baptized _____

How often do you read the Bible_____Never_____Occasionally_____Often_____Daily_____

Explain any recent changes in your religious life _____

WOMEN ONLY

Have you had any menstrual difficulties_____ Do you experience tension, tendency to cry, other symptoms prior to your cycle, please explain _____

Is your husband willing to come for counseling _____

Is he in favor of your coming _____ If no, explain_____

PROBLEM CHECK LIST

- | | | |
|--|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Depression | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Drunkenness | <input type="checkbox"/> Lust |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Envy | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Appetite | <input type="checkbox"/> Fear | <input type="checkbox"/> Moodiness |
| <input type="checkbox"/> Bitterness | <input type="checkbox"/> Finances | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Change in lifestyle | <input type="checkbox"/> Gluttony | <input type="checkbox"/> Rebellion |
| <input type="checkbox"/> Children | <input type="checkbox"/> Guilt | <input type="checkbox"/> Sex |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Health | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Conflict (fights) | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Wife abuse |
| <input type="checkbox"/> Deception | <input type="checkbox"/> Impotence | <input type="checkbox"/> A vice |
| <input type="checkbox"/> Decision Making | <input type="checkbox"/> In-laws | <input type="checkbox"/> Other |

