

WESTSIDE CHRISTIAN COUNSELING CENTER

INDIVIDUAL CONCERNS

Name	Date
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Check any of the following terms that apply to you (S = Self) or with a family member (F = Family).

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| <p>S F</p> <input type="checkbox"/> <input type="checkbox"/> Depressed mood
<input type="checkbox"/> <input type="checkbox"/> Lost interest or pleasure
<input type="checkbox"/> <input type="checkbox"/> Lack of energy/fatigue
<input type="checkbox"/> <input type="checkbox"/> Weight gain or loss
<input type="checkbox"/> <input type="checkbox"/> Unable to concentrate
<input type="checkbox"/> <input type="checkbox"/> Excessive sleeping
<input type="checkbox"/> <input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> <input type="checkbox"/> Decreased need for sleep
<input type="checkbox"/> <input type="checkbox"/> Pressure to keep talking
<input type="checkbox"/> <input type="checkbox"/> Racing thoughts
<input type="checkbox"/> <input type="checkbox"/> Excessive risk taking behavior
<input type="checkbox"/> <input type="checkbox"/> Panic Attacks
<input type="checkbox"/> <input type="checkbox"/> Excessive fear or situation or object
<input type="checkbox"/> <input type="checkbox"/> Reoccurring thoughts or impulses
<input type="checkbox"/> <input type="checkbox"/> Repetitive behaviors to reduce stress
<input type="checkbox"/> <input type="checkbox"/> Witness/experience event threatening life or serious injury
<input type="checkbox"/> <input type="checkbox"/> Excessive anxiety or worry
<input type="checkbox"/> <input type="checkbox"/> Hear/see things others do not
<input type="checkbox"/> <input type="checkbox"/> Memory problems/ Memory loss
<input type="checkbox"/> <input type="checkbox"/> Suicidal Thoughts | <p>S F</p> <input type="checkbox"/> <input type="checkbox"/> Significant ongoing physical pain
<input type="checkbox"/> <input type="checkbox"/> Stomach problems
<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Bowel problems
<input type="checkbox"/> <input type="checkbox"/> Balance problems
<input type="checkbox"/> <input type="checkbox"/> Seizure problems
<input type="checkbox"/> <input type="checkbox"/> Learning/Academic problems
<input type="checkbox"/> <input type="checkbox"/> Stuttering problems
<input type="checkbox"/> <input type="checkbox"/> Frequent problems with attention
<input type="checkbox"/> <input type="checkbox"/> Frequent "on the go" behavior
<input type="checkbox"/> <input type="checkbox"/> Impulsive behaviors
<input type="checkbox"/> <input type="checkbox"/> Temper
<input type="checkbox"/> <input type="checkbox"/> Aggressive behavior toward others
<input type="checkbox"/> <input type="checkbox"/> Destructive behaviors
<input type="checkbox"/> <input type="checkbox"/> Frequent lying/deceitfulness
<input type="checkbox"/> <input type="checkbox"/> Problems following rules
<input type="checkbox"/> <input type="checkbox"/> Sexual problems
<input type="checkbox"/> <input type="checkbox"/> Eating Problems
<input type="checkbox"/> <input type="checkbox"/> Nightmares
<input type="checkbox"/> <input type="checkbox"/> Gambling Problems | <p>S F</p> <input type="checkbox"/> <input type="checkbox"/> Alcohol usage
<input type="checkbox"/> <input type="checkbox"/> Drug usage
<input type="checkbox"/> <input type="checkbox"/> Marital problems
<input type="checkbox"/> <input type="checkbox"/> Divorce
<input type="checkbox"/> <input type="checkbox"/> Separation
<input type="checkbox"/> <input type="checkbox"/> Affair
<input type="checkbox"/> <input type="checkbox"/> Problems with ex/spouse
<input type="checkbox"/> <input type="checkbox"/> Relationship problems
<input type="checkbox"/> <input type="checkbox"/> Parenting problems
<input type="checkbox"/> <input type="checkbox"/> Problems with Friends
<input type="checkbox"/> <input type="checkbox"/> Problems with children
<input type="checkbox"/> <input type="checkbox"/> Legal problems
<input type="checkbox"/> <input type="checkbox"/> Work/job problems
<input type="checkbox"/> <input type="checkbox"/> Financial problems
<input type="checkbox"/> <input type="checkbox"/> School problems
<input type="checkbox"/> <input type="checkbox"/> Shyness
<input type="checkbox"/> <input type="checkbox"/> Anger
<input type="checkbox"/> <input type="checkbox"/> Loneliness
<input type="checkbox"/> <input type="checkbox"/> Insecurity
<input type="checkbox"/> <input type="checkbox"/> Isolation |
|---|--|--|

If you have noticed any recent changes in the following areas, please circle those changes.

Vision	Hearing	Coordination	Balance	Strength	Speech	Memory
Energy	Sleeping	Menstrual cycle	Elimination	Eating	Sexual activity	Thinking

List any additional medical problems you may experience: _____

List all medications you are taking:

Medication	Dosage	Prescribed by	Date prescription began
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List any counseling or therapy you or a member of your family are receiving or have received:

Therapist	Address	When	Family Member(s)
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Have you ever been physically, sexually, emotionally abused? No Yes

If yes, briefly describe: _____

Have you ever been hospitalized for mental or nervous problems? No Yes

If yes, when and where? _____

Have you ever attempted suicide? No Yes

If yes, where, when and how many attempts? _____

Are you suicidal now? No Yes

Do you drink alcohol? No Yes

If yes, what is your typical drink and how often do you drink alcohol? _____

Age first used alcohol _____ Age of heaviest/most frequent use _____ Use in last three months _____

Have you ever been arrested for driving under the influence (DUI)? No Yes If yes, how many times? _____

Do you use drugs? No Yes

If yes, what drugs do you use and how often? _____

Age first used drug(s) _____ Age of heaviest/most frequent use _____ Use in last three months _____

Have you ever been arrested? No Yes If yes, how many times and for what? _____

Are you currently involved or do you expect to be involved in any court-related matters? No Yes

If yes, please describe: _____

What is it in your marriage, family or individual life that brings you to therapy?

What kinds of stressors are you experiencing right now?

What important things about your marriage or family would it be helpful for your therapist to know? (i.e. illnesses, handicaps, deaths, divorces, school/job changes, suicide)

Do you have any concerns about violence or abuse in your family? Alcohol or drug usage? Please describe them.