WESTSIDE CHRISTIAN COUNSELING CENTER
INDIVIDUAL CONCERNS

Name	Date

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

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

_____

_____

_____

_____

List any counseling or therapy you or a member of your family are receiving or have received:

Therapist Address When Family Member(s)

_____

_____

_____

WESTSIDE CHRISTIAN COUNSELING CENTER
INDIVIDUAL CONCERNS

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.