WOODLAND WEST CHRISTIAN COUNSELING

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ADULT INFORMATION FORM

Full Name _____

Address _____

City/State _____ Zip _____

Home ( )_____ Work ( )_____ Cell ( ) _____

Email _____

Date of Birth _____ Age _____ Male _____ Female _____

Employer/Occupation_____

Current Marital Status ___Never married ___Married ___Divorced ___Separated
___Widowed ___Living Together

Name of Spouse (if applicable) _____

Date of Marriage _____

Previous Marital History:

Self:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____

Spouse:

Name of Previous Spouse	Date of Marriage	Date of Divorce/Death
_____	_____	_____
_____	_____	_____

Your Education Level: _____GED _____High School Diploma _____College Degree
_____ Graduate Degree Degree _____

Spouse's Education Level: ____GED ____High School Diploma ____College Degree
_____ Graduate Degree Degree _____
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Children:

Name	Gender	Age	Father/Mother's First Name
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____

Others Living In the Home with You:

Name	Relationship	Age	Grade/Occupation
_____	_____	___	_____
_____	_____	___	_____
_____	_____	___	_____

Are you currently attending a church? ____ Yes ____ No

If yes, what is the name of the church? _____

What is the denomination of the church? _____

Have you been baptized into Christ? ____ Yes ____ No ____ Unsure

Are religious or spiritual issues important in your life? ____ Yes ____ No

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problem? ____ Yes ____ No

If yes, what are they? _____

Who referred you to our center? _____

What are you seeking help for? _____

_____

_____

How much are you troubled by this?

_____ Constantly _____ Often _____ Somewhat _____ Not Very Much

Comments concerning this problem: _____

_____

_____

MEDICAL HISTORY

Primary Care Physician: _____ Phone #:_____

Please list any prescription medications you currently use:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any over-the-counter medications you currently use:

Medication	Dosage	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you rate your health? _____

How many hours do you sleep each night? _____

Have you had any recent change in sleep habits? ____Yes ____No

If so, please describe _____

How much exercise are you getting? _____

Do you experience food cravings? ____ Yes ____ No

If so, for what items? _____

Have you had any recent changes in your appetite? ____Yes ____No

If so, please describe _____

Have you recently lost or gained weight? ____ Yes ____ No

If so, how much?_____ In what time span?_____

How would you rate your diet?

____ Very healthy ____Healthy ____Average ____Needs Improvement ____ Poor

PSYCHIATRIC HISTORY

Have you ever received psychiatric or psychological treatment before? ____Yes____ No

What type of care did you receive?____Inpatient ____ Outpatient

Therapist Name: _____

Dates of treatment:_____

Presenting Problem:_____

Therapist Name: _____

Dates of treatment:_____

Presenting Problem:_____

Are you currently seeing a psychiatrist? ____Yes____ No

Name: _____ Phone #:_____

LEGAL HISTORY

Do you have any pending legal charges? _____

Have you ever been convicted of anything other than a misdemeanor? _____

If so, please describe _____

SUBSTANCE ABUSE HISTORY

Do you drink coffee? ____Yes____ No

How much?_____ How often?_____

Do you smoke cigarettes? ____Yes____ No

How much?_____ How often?_____

Do you drink alcohol?____ Yes____ No

How much?_____ How often?_____

Type of alcohol?_____

Have you ever abused drugs? ____Yes____ No

How much?_____ How often?_____

Which drug(s)?_____

THOUGHTS AND BEHAVIORS

Please check how often the following thoughts occur to you:

1. Life is hopeless.	___ Never	___ Rarely	___ Sometimes	___Frequently
2. I am lonely.	___ Never	___ Rarely	___ Sometimes	___Frequently
3. No one cares about me.	___ Never	___ Rarely	___ Sometimes	___Frequently
4. I am a failure.	___ Never	___ Rarely	___ Sometimes	___Frequently
5. Most people don't like me.	___ Never	___ Rarely	___ Sometimes	___Frequently
6. I want to die.	___ Never	___ Rarely	___ Sometimes	___Frequently
7. I want to hurt someone.	___ Never	___ Rarely	___ Sometimes	___Frequently
8. I am so stupid.	___ Never	___ Rarely	___ Sometimes	___Frequently
9. I am going crazy.	___ Never	___ Rarely	___ Sometimes	___Frequently
10. I can't concentrate.	___ Never	___ Rarely	___ Sometimes	___Frequently
11. I am so depressed/sad.	___ Never	___ Rarely	___ Sometimes	___Frequently
12. God is disappointed in me.	___ Never	___ Rarely	___ Sometimes	___Frequently
13. I can't be forgiven.	___ Never	___ Rarely	___ Sometimes	___Frequently
14. Why am I so different?	___ Never	___ Rarely	___ Sometimes	___Frequently
15. I can't do anything right.	___ Never	___ Rarely	___ Sometimes	___Frequently
16. People hear my thoughts.	___ Never	___ Rarely	___ Sometimes	___Frequently
17. I have no emotions.	___ Never	___ Rarely	___ Sometimes	___Frequently
18. Someone is watching me.	___ Never	___ Rarely	___ Sometimes	___Frequently
19. I hear voices in my head.	___ Never	___ Rarely	___ Sometimes	___Frequently
20. I am out of control.	___ Never	___ Rarely	___ Sometimes	___Frequently

Please comment (e.g., examples, frequency, duration, effects on you) about each of the above thoughts that occur frequently or are a concern to you. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

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_____

SYMPTOMS

Please check the behavior and symptoms that occur to you more often than you would like for them to take place.

___Aggression	___Fatigue	___Sexual Difficulties
___Alcohol Dependence	___Hallucinations	___Sick Often
___Anger	___Heart Palpitations	___Sleeping Problems
___Antisocial Behavior	___High Blood Pressure	___Speech Problems
___Anxiety	___Hopelessness	___Suicidal Thoughts
___Avoiding People	___Impulsivity	___Thoughts Disorganized
___Chest Pain	___Irritability	___Trembling
___Depression	___Judgment Errors	___Withdrawing
___Disorientation	___Loneliness	___Worrying
___Distractibility	___Memory Impairment	___Other (Specify)
___Dizziness	___Mood Shifts	_____
___Drug Dependence	___Panic Attacks	_____
___Eating Disorder	___Phobias/Fears	_____
___Elevated Mood	___Recurring Thoughts	_____

Please give examples of how each of the symptoms that you checked impairs your ability to function (i.e., socially, emotionally, occupationally, physically, etc.). Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

Whom should we contact in case of emergency?

Name _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____