INDIVIDUAL CONCERNS

(Please have each person over the age of 12 who will be attending counseling complete this 2-sided form.)

NAME _____ DATE _____

Circle the following terms which pertain to you or any of your family members. Indicate concerns for yourself with a "S" and concerns for family members with an "F".

Nervousness	Health Problems	Marital Problems	Drug Usage
Shyness	Stomach Problems	Divorce	Alcohol Usage
Spiritual concerns	Bowel Problems	Separation	Financial Problems
Loneliness	Depression	Affair	Problems w/Friends
Frustration	Headaches	Problems w/ ex-spouse	Can't Have Fun
Temper	Memory Loss	Stress	Tiredness
Self-Control	Sleeping Problems	Grief	Children
Insecurity	Nightmares	Parenting Problems	Career Choices
Fears	No Ambition	Relationship Problems	Problems w/Parents
Panic Attacks	Eating Problems	Legal Problems	Chronic Pain
Isolation	Suicidal Thoughts	Work Problems	School Problems
Can't Concentrate	Lack of Energy	Struggle making decisions	Anger

If you have noticed any <u>recent changes</u> in the following areas, <u>please circle those changes</u>

A) vision, hearing, coordination, balance, strength, speech, memory, or thinking

B) energy, sleeping, eating, elimination, menstrual cycle, or sexual activity

List any medical problems you have:_____

_____

List all medication you are taking and its purpose: _____

_____

How often do you drink alcohol? _____

Have you ever been arrested for driving under the influence (DUI)? **No Yes**

If yes, how many times? _____

Do you use any type of nicotine product (cigarettes, e-cigs, chewing tobacco)? **No Yes**

If yes, please specify type and frequency of use: _____

Do you use illegal drugs, or do you use prescription drugs in a way other than how they were prescribed?

No Yes

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

_____

Do you have any concerns about drug or alcohol usage by any members of your family? Who?

_____

_____

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

_____

_____

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 and when? _____

Are you currently experiencing suicidal thoughts? **No** **Yes**

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

_____

Are you now, or have you ever been involved in any sexual behaviors which have been problematic for yourself or someone else? **No** **Yes**
If yes, please explain: _____

_____

What is going on in your life, your marriage or family that brings you to therapy? _____

_____

_____

What kinds of stressors are you experiencing right now? _____

_____

_____

Do you consider yourself to be a spiritual person? **No** **Yes**

If yes, how do your spiritual beliefs/faith influence your presenting concerns?

_____

_____

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

_____

_____

What are you hoping will be different for you as a result of your participation in counseling?

_____

_____

_____

_____

Thank you for taking time to complete this form. Please be sure to bring it with you to your first appointment. This information is very helpful for your counselor to have as you begin the counseling process.