CHRISTIAN COUNSELING CENTER, LLC

A FAITH-BASED, BIBLICAL COUNSELING CENTER

The following information is needed to best help you. Please clearly print your response to each question. This will help save time in your first session. If you are unable to complete some parts, please leave them blank and you will have a chance to complete them with your counselor.

SECTION I: IDENTIFYING INFORMATION

Today's Date: _____

Name:_____

Other Name(s) Used: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone_____ Other: _____

E-mail Address (optional):_____

Date of Birth:_____ Social Security No._____ Age:_____

Gender: M / F Marital Status: S / M / D Children? Y / N How Many? _____

Emergency Contact:_____ Relationship: _____

Address:_____ Phone:_____

If under 18, with whom do you live? _____

Name / Age / Relationship to you:

_____

Contact Information (if different than above):

_____

Employer: _____

Address:_____City_____State____Zip Code_____

Spouse Employer:_____

Address:_____City_____State____Zip Code_____

Health Insurance Carrier Name:_____

ID No._____Group No._____ Eff Date_____

Insured's Name:_____Date of Birth_____

Claims Address_____City_____ ___State____Zip Code_____

Insurance Company Phone No._____

SECTION II: DESCRIPTION OF PRESENTING PROBLEM

Please state why you decided to come to the Christian Counseling Center of Las Vegas (CCC-LV):

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please tell us what you want to work on or change in counseling:

_____
_____
_____
_____
_____
_____
_____
_____

How long has this been a significant problem for you? *Please be specific (i.e., not "all my life").*

_____
_____
_____
_____
_____

How would you estimate the severity of the problem at this time? (Place "X" on the line below):
Mild _____ Moderate_____ Manageable_____ Serious_____ Severe _____

What symptoms are related to this problem? Please check **all** that apply for you **now**:

__overeating	__restless	__rapid heart rate	__compulsive behaviors
__taking drugs	__depressed mood	__sweating	__fears/phobias
__odd behavior/thoughts	__crying	__trembling or shaking	__anxiety
__recent weight gain	__difficulty concentrating	__shortness of breath	__vomiting
__recent weight loss	__low motivation	__muscle tension	__distrust
__recent appetite changes	__aggressive behavior	__outbursts of temper	__jumpy
__social withdrawal	__feeling worthless	__nightmares	__dizzy or lightheaded
__family emotional problems	__stomach problems	__easily distracted	__fatigue/loss of energy
__chest pain	__sleeping too much	__decreased sleep	__obsessions
__difficulty falling asleep	__problems with school	__housing problems	__relationship problems
__difficulty staying asleep	__pain	__drinking alcohol	__other: _____

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with academic program, relationship ending, past trauma, etc.):

In the past, what has been helpful to you in dealing with this problem?

SECTION III: MEDICAL HISTORY

Name and location of any past or present Physician/Psychiatrist/Psychologist and/or Counselor:

Date of your last physical exam:_____

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations):

Dates	Problem	Treatment	Hospitalized (Y/N)

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor? Yes ___ No ___

Date	Problem	Therapist	Helpful? (Y/N)

_____
_____

Have you ever been given a mental health diagnosis in the past from a mental health professional?
Yes____ No____

If yes, as you understand it, what is/was that diagnosis?
_____
_____
_____

SECTION IV: MEDICATIONS AND SUBSTANCES USED If applicable, please list all medications you are now taking or have taken in the past three months, **including birth control pills, vitamins, herbs and supplements**.

Please list the following, in order of date used:

- Medication
- Dosage
- Prescribing Physician
- How long have you been taking?
- Helpful (Y/N)

_____
_____
_____
_____
_____

If applicable, amount of **caffeinated** beverages per day:
coffee _____ soda _____ espresso _____ tea _____

If applicable, number of cigarettes smoked per day:_____

If applicable, how often do you use marijuana per week?_____

Think of the occasion that you drank the most in the **past month**.

- How much did you drink?_____
- How many hours did you drink?_____
- What did you drink?_____

If applicable, other substances used over the past year:
_____
_____
_____
_____

Do you use alcohol or drugs to (check all that apply):

- Manage stress?__
- To relax?__
- To change mood?__
- For sleep?__

SECTION V: FAMILY OF ORIGIN INFORMATION

- Parent/Guardian Age_____ Name _____
  Occupation_____ Deceased (Y/N) ____

- Parent/Guardian Age _____ Name_____
  Occupation_____ Deceased (Y/N) ____

If applicable:

- Stepparent Age _____ Name_____
  Occupation_____ Deceased (Y/N) ____

- Stepparent Age_____ Name_____
  Occupation_____ Deceased (Y/N) ____

- Sibling Age_____ Name _____
  Occupation_____ Deceased (Y/N) ____

- Sibling Age_____ Name _____
  Occupation_____ Deceased (Y/N) ____

- Sibling Age_____ Name _____
  Occupation_____ Deceased (Y/N) ____

- Sibling Age_____ Name _____
  Occupation_____ Deceased (Y/N) ____

If applicable (circle all that apply):

Children living with you? (Y/N/Part time)

Name(s) and age(s) of children:

_____
_____
_____
_____
_____

Are your parents divorced? Yes _____ No _____

Have any members of your family had problems with:

drugs ___ alcohol ___ depression ___ anxiety ___ diabetes ___ epilepsy ___

Other family mental illness (please describe): _____

Who Had?_____
Relationship?_____
When?_____ Current?: Y / N

Who Had?_____
Relationship?_____
When?_____ Current?: Y / N

Among your friends and family, whom do you count on for emotional support?
_____
_____
_____
_____

Are you:

- Single ___
- Dating ___
- Married / Partnered ___
- Divorced / Un-partnered ___
- Widowed / a Surviving Partner ___

If applicable, describe your relationship with your current partner (place an X on the line below):

Major Problems_____ Minor problems_____ Satisfactory_____ Very satisfactory_____

How long have you been in the relationship? _____

Is there anything else we need to know to assist you? Please use the space below or ask for an extra sheet of paper if needed.