



Abiding Hope

Christian Counseling

Christina Ashby, LMSW
Supervised by Ginger Gray, LCSW-S

19115 FM 2252 Ste. 12

San Antonio, TX 78266

Voice mail: 210-816-2261

www.abidinghopecc.com

PLEASE PRINT

TODAY'S DATE: _____	HOME PHONE: _____
NAME: _____	CELL: _____
ADDRESS: _____	D.O.B. _____
CITY, STATE, ZIP: _____	STATUS: S M D W
E-Mail address: _____	
INSUREDS NAME: _____	INSUREDS DOB : _____
INSURANCE COMPANY _____	
INS. I D # _____	INS. GROUP # _____
REFERRED BY: _____	

Are you comfortable with the therapist praying at the end of each session? ____

Briefly list the reason for your visit? _____

Current occupation? _____

How would you describe your present health? (excellent, good, fair, poor)

A. Physical _____

B. Emotional _____

C. Spiritual _____

Are you currently sexually active? _____

Marriage: Currently married/divorced/single

Spouse: _____ Age: _____

Occupation: _____ Year married: _____

Children (list ages): _____

Describe marriage _____

Any previous marriages by you or your spouse? _____

Any financial problems at present? _____

Legal problems? _____

Ever arrested? _____

Military service? _____

Do you have any hobbies or interests? _____

Who are your friends now? _____

Circle any of the following that apply to you:

Headaches	Dizziness	Fainting spells	Palpitations
Stomach trouble	Poor/no/excessive appetite	Weight loss/gain	Bowel troubles
Excessive sweating	Trouble falling asleep	Fitful sleep	Nightmares
Early morning awakening	Hate to get up	Bad home/living conditions	Financial problems
Disbelief in God	Changed value system	Not living up to religious obligations	Quick to anger
Crisis of faith/identity	Conflict with authority	Spiritual problems	Fear of dying/losing mind/having cancer
Change mind often	Uncontrollable outbursts	Frequent job changes	Find praying meaningless
Unpredictable moods	Very selfish	Unstable	Hard to deny self
Indecisive	Feel helpless	Thoughts of death/suicide	Impulsive behavior
Compulsion to do certain things	Hard/unable to make friends	Hopeless	Obsessive thoughts
Guilty	Depressed	Worthless	Ashamed
Afraid of people	Fear of hurting one's feelings	Eager to please	Shy
Sexual problems	Unloved	Scrupulous	Feel inferior
Unable to have good time	Fussy	Don't care about anything	Inadequate
Worried	Don't like weekends/vacations	Can't sit still	Perfectionist
Feel tense	Unable to relax	Lonely	Panicky
Tremors	Alcoholic	Smoke pot	Fearful
Overly suspicious	Personality change	Driven	Drink more than socially
Forgetful	Disoriented	Anxious	Strange sensations
Confused	Use drugs	Hard to concentrate	Blackouts
Take sleeping pills	Tired	Exhausted	Memory loss

Other symptoms not mentioned above:

Are you presently taking medication? _____ If so, what? _____

Have you ever been under the care of a psychiatrist or therapist?

Yes _____ No _____ If yes, with whom and what was the nature of the treatment?

Are you currently under the care of a psychiatrist or therapist?

Yes _____ No _____ If yes, with whom and what is the nature of the treatment?

Have you received any psychological testing? _____

Do you use alcohol or other drugs on a regular basis and if so, how often? _____

Brief MAST

-
- 1. Do you feel you are a normal drinker? Yes____No____
 - 2. Do friends or relatives think you are a normal drinker? Yes____No____
 - 3. Have you ever attended a meeting of Alcoholics Anonymous(AA)? Yes____No____
 - 4. Have you ever lost friends or girlfriends/boyfriends because of drinking? Yes____No____
 - 5. Have you ever gotten into trouble because of drinking? Yes____No____
 - 6. Have you ever neglected your obligations, your family, or your work for two or more days in a row because of drinking?
Yes____No____
 - 7. Have you ever had delirium tremors (DT's), severe shaking, heard voices or seen things that weren't there after heavy drinking? Yes____No____
 - 8. Have you ever gone to anyone for help about your drinking? Yes____No____
 - 9. Have you ever been in a hospital because of drinking? Yes____No____
 - 10. Have you ever been arrested for drunk driving or driving after drinking? Yes____No____

Childhood:

Names of parents & siblings_____

Are they living?_____

Is there any family history of mental or emotional illness?_____

Briefly describe what it was like growing up in your home_____

Describe discipline used in your home/who enforced it?_____

Was mother's pregnancy (with you) & delivery normal? Any complications? Were all developmental milestones (walking, talking, toilet training) met at normal times? Normal childhood diseases?_____

Any hospitalizations, trauma (including sexual or physical abuse) while growing up?_____

Any outstanding memories (positive or negative) regarding elementary, middle, or high school? _____

Highest grade completed _____
Any learning disabilities? _____

What are your ambitions/goals?

What do you consider your greatest assets/strengths/talents/capabilities?

What do you consider your weaknesses? _____

How is most of your free time occupied? _____

Does your present way of life and work satisfy you? _____

In what way of life/work do you think you would be happiest? _____

What is the role of religion/spirituality/church in your life, both past and present?

Denomination? _____

Anything else that I should know? _____
