CLIENT/THERAPIST ____ / ____

Abiding Hope Christian Counseling, Ltd.
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PLEASE PRINT

TODAY'S DATE: ____________________ **HOME PHONE:** _________________

NAME: ____ **CELL:** _________________

ADDRESS:
____ **D.O.B.** _________________

CITY, STATE, ZIP: _______________________________________ **STATUS: S M D W**

E-Mail address: ____

REFERRED BY: ____

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

Briefly list the reason for your visit?____________________________________

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____

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?____________________________

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Any financial problems at present?_______________________________________

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____

Legal problems?____

____

Ever arrested?____

Military service?____

____

Do you have any hobbies or interests?____________________________________

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____

Who are your friends now?____

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CLIENT/THERAPIST ____ / ____

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:

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____

Are you presently taking medication?__________ If so, what?________________

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____

____

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?____

CLIENT/THERAPIST ____ / ____

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?____________________

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____

Briefly describe what it was like growing up in your home___________________

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

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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?____

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

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

Highest grade completed____

Any learning disabilities?____
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What are your ambitions/goals?

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____

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

____

____

What do you consider your weaknesses?___________________________________

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____

How is most of your free time occupied?___________________________________

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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?

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____

Denomination?____

Anything else that I should know?_______________________________________
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