CORNERSTONE CHRISTIAN COUNSELING

Name_____ **Sex: M F Social Security #**_____
Address_____ **Date of Birth**_____ **Age**_____
City_____ **ST**_____ **Zip Code**_____ **Home Phone**_____
Employer Work Phone_____
Email Address_____ **Cell Phone**_____
Marital Status (circle one): Single Married Separated Divorced Widowed
Emergency Contact_____ **Relationship**_____ **Phone**_____

INITIAL ASSESSMENT

Date_____
Your reason for seeking counseling?_____
_____
_____
_____

Is there anyone you want involved in your counseling? (ex: spouse, pastor, teacher, etc.)_____
_____

EMPLOYMENT HISTORY

Current Employer _____**Length of employment**_____
Position/Title_____ **Job satisfaction**_____

LEGAL SYSTEM INVOLVEMENT

Have you ever been involved with the legal system? _____**If yes, please explain**_____
_____
_____
_____

MILITARY HISTORY

Were you in the military service? Yes/No Branch Enlisted? _____**Drafted?**_____
Tour Dates _____**Served** _____**Combat Yes/No Stationed**_____
Disability or pension _____**Type of discharge**_____

EDUCATIONAL HISTORY

Highest grade completed?_____ **Name of school**_____
Area of study_____ **Do/did you like school?** _____**Explain**_____
_____
_____
Describe school performance _____
Have you ever been diagnosed with a learning disability?_____ **Explain** _____
_____
_____
Have you ever been diagnosed with ADD/ADHD? _____

MARITAL/RELATIONSHIP HISTORY

Current Spouse's Name _____ Age _____ Length of Marriage _____
Length of Engagement _____ Length of Dating Relationship_____
Were you previously married? Y e s No **Was your spouse?** Yes No

BROTHER'S & SISTER'S (full or step or half)

Name	Age	Occupation	Marital Status

CHILDREN/STEP CHILDREN

Name	Age	Relationship (child, stepchild, adopted)	Lives with you?

FAMILY HISTORY

Father's Name_____ Age_____
Education_____ Occupation_____
Mother's Name_____ Age_____
Education_____ Occupation_____
Marital status of parents:_____

Step Father's Name_____Age_____
Education_____ Occupation_____
Step Mother's Name_____ Age_____
Education_____ Occupation_____

Where were you born?_____ Who raised you?_____
Were you adopted? Yes No **If yes, at what age?_____**

FAMILY HISTORY (cont)

Have you or any member of your family experienced any of the following? (check all that apply)

ADDICTIONS

- ☐ **Alcohol: Who?**_____
- ☐ **Drugs: Who?**_____
- ☐ **Food/Eating: Who?**_____
- ☐ **Gambling: Who?**_____
- ☐ **Sex/Pornography: Who?**_____
- ☐ **Relationship/Love: Who?**_____
- ☐ **Other Who?**_____

EMOTIONAL PROBLEMS

- ☐ **Depression: Who?**_____
- ☐ **Anxiety: Who?**_____
- ☐ **Panic Attacks: Who?**_____
- ☐ **Manic/Depression: Who?**_____
- ☐ **Obsessions: Who?**_____
- ☐ **Suicide attempts or completion:**_____ **Who?**_____
- ☐ **Phobia/fears: Who?**_____
- ☐ **Anger/Explosive: Who?**_____
- ☐ **Other: Who?**_____

Have you or any member of your family been hospitalized for any of the above? Yes No

If yes, Who?_____

ABUSE: (to self/family member)

- ☐ **Physical: Self/Family?**_____ **by whom?**_____
- ☐ **Emotional: Self/Family?**_____ **by whom?**_____
- ☐ **Sexual: Self/Family?**_____ **by whom?**_____
- ☐ **Spiritual: Self/Family?**_____ **by whom?**_____

Did you ever witness violence in your home or elsewhere while growing up? Yes No **If yes, explain**_____

_____

_____

PHYSICAL, PSYCHOLOGICAL AND SOCIAL HISTORY

Physicians's Name_____ **Name of Practice**_____

Address_____ **Phone**_____

Date of last visit_____ **Reason**_____

List any current or past medical conditions_____

_____

List any surgeries and dates_____
_____
_____
List any abortion(s) and dates_____
List all current medications (dosage, frequency and purpose)_____
_____
_____
Do you drink alcohol?_____**I f y es, how much and how often?**_____
Do you smoke cigarettes or chew tobacco? _____**I f yes, how much and how often?**_____
Do you consume caffeine?_____ **If yes, how much and how often?**_____
List any allergies_____
List past use of medications for depression, anxiety, ADD/ADHD, sleep, weight control, smoke cessation, etc.?
_____
_____
_____

PREVIOUS COUNSELING

Have you ever had formal counseling? _____**How many times?**_____
With whom?_____
When?_____**Why?**_____
_____
Was it inpatient or outpatient?_____
Was it helpful?_____ **Explain**_____
_____
Describe the last major change in your life_____
_____
_____
Describe any losses that you have experienced (i.e. health issues, death, divorce, pregnancy loss, retirement, moves, etc.) _____
_____
_____

CURRENT SYMPTOM CHECKLIST:

Are you currently experiencing any of the following? Please Check all that apply.

____ Anxiety/Nervousness	____ Anger	____ Bad dreams/nightmares	____ Compulsive Behaviors
____ Crying often	____ Depression	____ Easily Annoyed	____ Violent Thoughts
____ Mood Swings	____ Loneliness	____ Loss of Hope	____ Trouble Managing Money
____ Obsessive Thoughts	____ Racing Thoughts		____ Weight Loss or Gain
____ Sexual problems	____ Panic Attacks	____ Trouble Concentrating	____ Trouble Sleeping
____ Irritable Bowel	____ Fatigue	____ Work Problems	____ School Problems
____ Headaches	____ Low Self Esteem	____ Social Withdrawal	____ Backaches
____ Seizures	____ Restlessness	____ Problems in Relationships	____Other:

HISTORY

Do you have people in your life that you consider close friends?_____
When going through a difficult experience in your life do you have someone to confide in?_____
What activities/hobbies do you enjoy participating in?_____
Are you a member of any groups or organizations?_____ Explain_____
_____
_____
List two strengths about yourself_____
_____
_____
List two things about yourself that you would like to change?_____
_____
_____

SPIRITUAL HISTORY

Are you affiliated with a church?_____If yes, which church? _____
Pastor's name_____
Address_____ Phone_____
How involved are you in the congregation?_____
Attendance: Never_____ Sometimes _____Regularly_____

ADDITIONAL INFORMATION

What else should your therapist know about you?_____
_____
_____
_____
_____

Therapist Date of assessment review_____