



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? Yes No Was your spouse? Yes No

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

| Name | Age | Occupation | Marital Status |
|------|-----|------------|----------------|
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CHILDREN/STEP CHILDREN

| Name | Age | Relationship (child, stepchild, adopted) | Lives with you? |
|------|-----|--|-----------------|
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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? _____ If yes, how much and how often? _____

Do you smoke cigarettes or chew tobacco? _____ If 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.

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