HOPE UNLIMITED

Counseling by Ben Meek, LCMFT

Background Information

Name _____ Social Security # _____Date of Birth _____

Street _____ City _____ State ____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Do we have your permission to call you at these numbers? (yes / no) Home _____ Work _____ Cell _____

Do we have your permission to leave a message at these numbers? (yes / no) Home _____ Work _____ Cell _____

Are you open to brief contact by email? Yes ___ No ___ If yes, give address: _____

Employer _____ City _____

If married, how many years? _____ Previously married? _____ # of children from earlier relationship(s) ____

Names in your household:	Age	Relationship	Names in your household	Age	Relationship
_____			_____		
_____			_____		
_____			_____		

Religious Preference _____ Are you active in a church? _____

Would you like to include in your counseling: How faith can make a difference ___ Scripture ___ Prayer___ N/A___

Would you describe your spiritual beliefs as producing … Comfort ___ Stress ___ Both ___ N/A ___

Who referred you (or how did you know about Hope Unlimited)? _____
Briefly describe the reason you are coming for counseling _____
_____
_____
_____

How are things going in the following areas? Circle the number that indicates the current situation.

Area	Doing well …….. Needs help ……. Impairment					Comments
Marriage	1	2	3	4	5	_____
Family	1	2	3	4	5	_____
Friends	1	2	3	4	5	_____
Job /School	1	2	3	4	5	_____
Recreation	1	2	3	4	5	_____
Medical	1	2	3	4	5	_____
Housing	1	2	3	4	5	_____
Financial	1	2	3	4	5	_____
Legal	1	2	3	4	5	_____

Areas of Concern:

Sleep: Good ___ Difficulty falling asleep ___ Wake and unable to fall back asleep ____ Nightmares _____

Appetite: Good ___ Fair ___ Poor ___ Weight changes: Gain ___ Loss ___ No change ___ Since when: _____

Energy level: Good ___ Fair ___ Poor ___ Concentration: Good ___ Fair ___ Poor ___ Chronic pain: Yes ___ No ___

Sexual desire: Good ___ Fair ___ Poor ___ Sexual Activity: Good ___ Fair ___ Poor ___ N/A ___

Loss of Interests in work of hobbies? Yes ___ No ___ Comments: _____

Feelings of Hopelessness? Yes ___ No ___ Feelings of Helplessness? Yes ___ No ___ Stress level: High ___ Low ___

Suicidal / Homicidal: Thoughts ___ Intent ___ Plan ___ None ___ Comments: _____

Repetitive unwanted thoughts: _____

Are you experiencing specific fears? _____

Do you feel especially: Lonely ___ Worthless ___ Resentful ___ Irritable ___ Nervous ___ Quick to react ___

Crying spells? Yes ___ No ___ Frequency _____ Headaches? Yes ___ No ___ Frequency _____

History of abuse: Physical ___ Sexual ___ Mental ___ Comments: _____

Significant Trauma or Grief events experienced: _____

Describe any prior mental health treatment: _____

What symptoms are you experiencing at this time? _____

_____How long have you had these symptoms? _____

How severe have these symptoms been? Come and go ___ Mild ___ Moderate ___ Severe ___ Disabling ___

Indicate any recent health changes: _____

Currently taking an antidepressant? Yes ___ No ___ Which one? _____ Previously taken? Yes ___ No ___

Health Issue	Symptoms	Medication Prescribed	Dosage

Other non prescription drugs you use: _____

Doctor _____ Address _____ Phone _____

Alcohol use? Yes ___ No ____ If yes, average number of drinks per week? _____

Drug use? Yes ___ No ___ If yes, does this cause problems in relationships? Yes ___ No ___

Do you have any concern about the level of physical conflict in the home? Yes ___ No ___ If yes, explain:

_____

_____

Family History: Have any of your close relatives had any of the following conditions?

Alcoholism: Yes ___ No ___ If yes, who? _____

Anxiety Yes ___ No ___ If yes, who? _____

Depression Yes ___ No ___ If yes, who? _____

Bipolar Yes ___ No ___ If yes, who? _____

ADHD Yes ___ No ___ If yes, who? _____

Addition Yes ___ No ___ If yes, who? _____

Mental Illness Yes ___ No ___ If yes, who? _____

Suicide Yes ___ No ___ If yes, who? _____

Violence Yes ___ No ___ If yes, who? _____

Describe what you hope may be accomplished during the process of counseling:

_____

_____

_____

_____

_____

_____

_____

Who may we contact in case of an emergency?

Name	Relationship to you	Address	Phone

_____

Will they know you are in counseling? Yes ___ No ___

Signature _____ Date _____