DOOR of HOPE COUNSELING

BACKGROUND: ADULT

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you after the form is reviewed.

GENERAL INFORMATION

*Name:*_____ *Date of First Visit:* _____
Last First MI

Home Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)

Work Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)

Cell Phone: _____ (***May call?*** Yes No ***May Leave Message?*** Yes No)

Best Time and Place to call: _____

Address: _____
Street City State Zip

Gender: _____ *Age* ____

Date of Birth: _____ *Occupation:* _____

Employer: _____ *How Long:* _____

Ethnicity:
___African American ___Bi-racial ___Hispanic/Latin
___Asian ___Caucasian ___Native American Other _____

Are you presently receiving counseling elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No
(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency: _____
Name Address

Phone: _____ Dates of Service: _____ (beginning - ending)

Previous Mental Health Professional/Agency: _____
Name Address

Phone: _____ Dates of Service: _____ (beginning - ending)

Please list additional at the bottom of this form if necessary.
Have you ever been hospitalized for mental health concerns? Yes No

Located on the campus of Freedom Fellowship Church
410 Oak Run Point, New Braunfels, TX 78132
Phone: 830-632-5039

If yes: When _____ Where_____

Are you seeking services because you are a victim of a crime? Yes No

Did it result in legal action? Yes No *(If Yes, explain)*_____

Education Level:
___8th grade or below ___High School ___GED
___Trade School/Some College ___Undergraduate Degree ___Graduate Degree

Current living arrangements:
___Family of origin ___Single ___Spouse/Partner ___Roommate ___Other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
_____Never married _____Currently married _____Divorced ___ ___Widowed

Marital History
___Number of Marriages ___Number of Divorces

List your current family, beginning with the oldest member:
Primary Household (anyone who currently lives in your household)

How long in this current living situation: _____

Name	Age	Gender	Relationship to you

RELIGION / SPIRITUALITY

Does religious faith play an important part in the life of your family? Yes No

If so, what faith community do you belong/attend: _____

What religious/spiritual activities does your family participate in? For example, daily prayer, reading of scripture, etc.

_____

_____

_____

_____

_____

_____

_____

HEALTH

Date of LAST complete physical: _____

Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain) _____

Check the following items for a diagnosis or medication that you are now receiving or have received:

Diagnosis	**Current** (list dates)	**Past** (list dates)	**Physician's Name**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Bipolar	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

What other medication are you currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT CONCERNS

Circle the item that you see as the most significant issue. Underline any additional concerns.

Problems Related to Abuse

Current or past physical abuse
Current or past sexual abuse
Current or past emotional abuse
Current or past neglect
History of abandonment
Suspected sexual abuse
Current or past family domestic violence

Work/School Problems

Learning difficulties
Problems with peers
Problems with authority figures
Problems with employees
Time Management
Stress management

Mood-related Concerns

Disturbing memories
Difficulty going to sleep/staying asleep
Nightmares/night terrors
Suicidal ideation
Sadness
Depression
Feelings of guilt and shame
Excessive worrying

Family Relationship Concerns

Difficulty adjusting to family changes
Marital concerns
Parent-child relationship problems
Sibling concerns
Divorce/Separation
Grief/ Loss

Behavior Concerns

Aggression toward others
Drug/alcohol use
Outbursts of anger
Gender identity concerns
Inappropriate sexual behavior
Intentionally hurting others
Hyperactive/Inattentive
Other unusual behaviors (please specify) _____

Religious/Spiritual Concerns

Current or past spiritual abuse
Recent change in beliefs / churches

Remember to circle the most significant issue.

When did you first become concerned about the main/most significant issue?_____

How have you attempted before now to deal with this issue? _____

_____

_____

_____

_____

_____

_____

_____

_____

HISTORY OF TRAUMA and/or STRESSORS

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …swear at you, insult you, put you down, or humiliate you? **Or,** act in a way that made you afraid that you might be physically hurt?
   Yes No
2. Did a parent or other adult in the household **often** …push, grab, slap, or throw something at you? **Or,** ever hit you so hard that you had marks or were injured?
   Yes No
3. Did an adult or person at least 5 years older than you **ever**…touch or fondle you or have you touch their body in a sexual way? **Or,** Try to or actually have oral, anal, or vaginal sex with you?
   Yes No
4. Did you **often** feel that …no one in your family loved you or thought you were important or special? **Or, y**our family didn't look out for each other, feel close to each other, or support each other?
   Yes No
5. Did you **often** feel that …you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **Or,** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No
6. Were your parents **ever** separated or divorced?
   Yes No
7. Was your mother or stepmother: **Often** pushed, grabbed, slapped, or had something thrown at her? **Or, sometimes or often** kicked, bitten, hit with a fist, or hit with something hard? **Or ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No
10. Did a household member go to prison?
    Yes No

History of learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity in the family: Yes No
(If yes, please explain) _____

Has you been abused (check all that apply): _____Physically _____Emotionally _____Sexually _____Spiritually

History of health/physical problems includes: (check all that apply):

_____Asthma
_____Bedwetting
_____Neurological problems/exam
_____Severe PMS
_____Heart Palpitations
_____Shortness of breath without exertion
_____Sleep problems
_____Surgeries
_____Nervous stomach
_____Dizziness
_____Severe Headaches
_____Chest pain
_____Serious overeating/under-eating
_____Major accident
_____Chronic Diarrhea
_____Other_____

Anything else you think we need to know? _____

_____

_____

What is the one thing we need to know to help you today? _____

_____

ANY OTHER INFORMATION YOU THINK WOULD BE HELPFUL

Thank you.