



In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone/Cell number \_\_\_\_\_

1. Please circle all that apply. Have you Experienced or Witnessed any of the following trauma situations? At what age? How long?

	Age/Time		Age/Time
Sexual Abuse	E/W	Verbal Abuse	E/W
Physical Abuse	E/W	Emotional Abuse	E/W
Loss/Grief	E/W	Major Accident	E/W

Other: \_\_\_\_\_

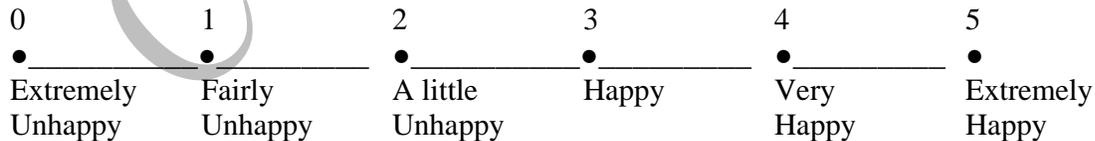
2. Have you experienced any of the following symptoms of depression? (Please Circle and put a checkmark next to symptom if it has been in the last 30 days)

- Fatigue/Low Energy      Hopelessness      Slow decision-making
- Sleeping a lot      Withdrawn      Slow thinking
- Speaking/Moving slow      Difficult sleeping      Feeling worthless
- Loss of interest of normal activities      Suicidal thoughts      Feeling blue

3. Have you been hospitalized for: (Please check and indicate when)

- Alcoholism      Depression      Emotional Issues      Substance abuse

4. **Relationship History:** The dots on the following line represent different degrees of happiness in your life. The middle point, "happy," represents the degree of happiness in most person's lives. Please circle the dot which best describes the degree of happiness, all things considered, of your life.



5. Are you on any medication? No      Yes

If so, which and what for \_\_\_\_\_

6. Have you used/using any of the following substances:

- Alcohol      Illicit drugs      Prescription medications (abused)      Other:

7. Have you experienced suicidal thoughts? Yes, Currently      Yes, Past      No

\_\_\_\_\_ (Initial)

- 8. Have you experienced *homicidal thoughts*? Yes, Currently Yes, Past No
- 9. Have you experienced **suicidal attempts**? Yes No How many times? \_\_\_\_\_
- 10. Have you experienced *homicidal attempts*? Yes No How many times? \_\_\_\_\_

**Problems that brought you to counseling:**

From your point of view, what major problems with your life brought you to counseling and what do you consider to be the most serious problem?

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**List one thing you think you could personally do to improve your situation.**

**What would you like to accomplish as a result of counseling?**

<p>Have you ever been to counseling as a result of this or these problems prior to today? (Circle: Yes or No) If so, what was the outcome of that counseling?</p>
<p>Have you been in individual counseling before? (Circle: Yes or No) If so, give a brief summary:</p>
<p>Are you currently or have you ever been homeless? (Circle: Yes No) If yes, when and for how long?</p>
<p>Do you drink alcohol to intoxication or take drugs to intoxication? (Circle: Yes or No) If yes for either, how often and what is your drug(s) (or alcohol) of choice? Do you have a family history of addiction? If so, who.</p>
<p>Has there been or currently is there a partner who struck, physically restrained, used violence against or injured you within the last three years? (Circle: Yes or No) If yes for either, who, how often and what happened?</p>

\_\_\_\_\_ (Initial)

What is your current level of stress? (Circle one) Extremely high ___ Very high ___ High ___ Moderate Low ___ Very low ___ Extremely low (10) (5) (0)
To what degree do you have family or friends that support you? (Circle one) Extremely high ___ Very high ___ High ___ Moderate Low ___ Very low ___ Extremely low

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