Wellspring Counseling

Partnering with churches and community for affordable care

CLIENT INFORMATION (CONFIDENTIAL)

CLIENT'S NAME_____ DOB_____ Age_____ Sex_____

☐ Minor ☐ Unmarried ☐ Married, Number of Years _____ ☐ Separated ☐ Divorced ☐ Widowed

Address_____ City_____ State_____ Zip_____

Phone: Home (_____)_____-_____ Work (_____)_____-_____ Cell (_____)_____-_____

E-mail_____ Occupation_____ Total hours/week_____

Employer_____ Phone_____

FAMILY MEMBERS	AGE	OCCUPATION/GRADE
Spouse_____	_____	_____
Children_____	_____	_____
Children_____	_____	_____
Children_____	_____	_____
Children_____	_____	_____

CLOSEST FRIEND/RELATIVE, NOT LIVING AT YOUR HOME, TO CONTACT IN THE EVENT OF EMERGENCY

Name (First/Last)_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Phone: Home (_____)_____-_____ Work (_____)_____-_____ Cell (_____)_____-_____

REFERRAL

Name (First/Last)_____ Organization/Church_____

Have you/any family member ever been treated at Wellspring Counseling? Yes No

If "Yes," Name of Counselor_____ When (approx.)_____

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Life History Questionnaire

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other_____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

☐ Other _____

Symptoms / Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Being Good to Yourself
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Night Mares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other_____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have or medications that you are on:

Anything else you would like us to know about you: