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Individual, Couple & Family Therapy
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INDIVIDUAL CONCERNS

Name	**Date**

Place a check in the columns next to each of the following terms that pertain to yourself or a family member.

	Self	Family		Self	Family		Self	Family		Self	Family
Anxious			Can't concentrate			Stress			Alcohol usage		
Fears			Can't have fun			Grief			Drug usage		
Feeling "keyed Up"			Depression			Difficulty making adjustments			Marital problems		
Impulsiveness			Difficulty making decisions			Chronic Pain			Affair		
Insecurity			Hopelessness			Chronic illness			Separation		
Nervousness			Isolation			Health problems			Divorce		
Panic attacks			Lack of energy			Eating problems			Problems w/ex-spouse		
Recurring thoughts			Loneliness			Sleeping problems			Problems w/children		
Anger			Memory loss			Career choices			Parenting problems		
Frustration			No Ambition			Financial problems			Problems w/parents		
Self-control			Tiredness			Legal problems			Problems w/friends		
Temper			Suicidal thoughts			Work problems			School problems		

List any MEDICAL ISSUES you have, the MEDICATIONS you are taking, and the approximate date when you started taking the current dosage:

Medical Issue	History	Current	Medication/Date prescribed	History	Current

Please indicate any RECENT CHANGES in the following areas of your functioning:

	No	Yes		No	Yes
Vision			Energy		
Stomach pain			Bowel problems		
Headaches			Sleeping		
Hearing			Eating		
Coordination			Elimination		
Balance			Menstrual Cycle		
Strength			Sexual Activity		
Memory			Weight		
Concentration			Other _____		

Please see other side for additional information

Please answers the following questions and provide a brief explanation for those to which you answer "yes".

	No	Yes
Have you ever been physically, sexually, emotionally abused?		
If yes, when? _____ by whom? _____		
Have you ever been hospitalized for mental or nervous problems?		
If yes, when? _____ where? _____		
Have you ever attempted suicide?		
If yes, when? _____ where? _____ how? _____		
Are you suicidal now?		
How often do you drink alcohol? (*place a check next to your response*) ____ Multiple times/day _____ Daily ____Weekly ____Monthly ____Rarely ____Never		
Have you ever been arrested for driving while intoxicated (DWI)?		
If yes, how many times? ____Once ____Twice ____More than twice		
Do you use drugs?		
If yes, What drugs do you use? _____ How often do you use drugs? (*place a check next to your response*) ____ Multiple times/day _____ Daily ____Weekly ____Monthly ____Rarely		
Do you have any concerns about drug or alcohol usage by any members of your family?		
If yes, who?		
Have you ever been arrested?		
If yes, How many times? ____Once ____Twice ____More than twice What were you arrested for each time? _____		
Are you currently involved or do you expect to be involved in any court-related matters?		
If yes, please describe:		

List other current or previous counseling you or a member of your family has received:

Counseling Type	**What problem(s) were addressed?**	**Who attended counseling?**	**Dates**
Individual	_____	_____	_____
Couple	_____	_____	_____
Family	_____	_____	_____
Drug/Alcohol	_____	_____	_____
Group	_____	_____	_____

What brings you to therapy *now*?