

**DOUG VALOT, STAFF COUNSELOR
SUSAN SOWELL, MA, LPC-S
KINGSLAND BAPTIST CHURCH
20555 KINGSLAND BLVD.
KATY, TEXAS 77450
281.492.0785**

DATE: _____

PERSONAL HISTORY

PLEASE ANSWER ALL QUESTIONS HONESTLY.

THE DEGREE OF YOUR HEALING IS RELEVANT TO THE DEGREE OF TRANSPARENCY.

ALL INFORMATION IS CONFIDENTIAL.

GENERAL INFORMATION

NAME: _____

ADDRESS: _____ EMAIL: _____

HOMEPHONE: _____ WORKPHONE: _____ CELL PHONE: _____

BIRTH DATE: _____ AGE: _____ MARITAL STATUS: _____

IF MARRIED, SPOUSE'S NAME: _____ NUMBER OF YEARS: _____

NUMBER OF CHILDREN:

_____ AGES: _____

OCCUPATION:

HOBBIES/INTERESTS:

HEALTH INFORMATION

Rate your health:

_____ very good _____ good _____ average _____ declining _____ other

If you are currently under a physicians care, please explain.

Please list any (past/present) significant illnesses, injuries and/or handicaps:

When was your last medical examination?

Results:

Are you presently taking medication? If yes, please describe.

ADDITIONAL INFORMATION

Have you ever had a severe emotional upset? If yes, what were the circumstances?

Have you ever been admitted to a hospital or treated for any psychotherapy or counseling?

Please list below any previous counseling you have had and dates of treatment.

Have you recently suffered the loss of someone who was close to you? If yes, please explain:

Have you recently experienced a significant change or traumatic experience? If yes, please explain.

Are you able to cope with all of your present circumstances? If no, please explain.

If you could change your present circumstances, what would you change?

Why are you seeking counseling?

Would you say your problems are more:

_____ Physical _____ MENTAL _____ EMOTIONAL _____ SPIRITUAL IN NATURE

CURRENT SYMPTOMS
CHECK ALL THAT APPLY

- | | |
|---|--|
| _____ Anxious thoughts | _____ Excessive dieting |
| _____ Excessive eating | _____ Compulsive exercising |
| _____ Compulsive sexual behaviors | _____ Feelings of hopelessness |
| _____ Disturbance of thought | _____ Unusual fears |
| _____ Thoughts of suicide | _____ Change in weight |
| _____ Change in sleep | _____ Sleep disturbances |
| _____ Hearing voices | _____ Change in appetite |
| _____ Change in personal relationships | _____ Health problems |
| _____ Increase/decrease in sex drive | _____ Panic attacks |
| _____ Anger outbursts | _____ Obsessions/Compulsions |
| _____ Hyperactivity | _____ Depressed mood |
| _____ Feelings of being overwhelmed | _____ Loss of interest in activities |
| _____ Poor memory | _____ Daydreaming |
| _____ Forgetfulness | _____ Guilt |
| _____ Feelings of helplessness | _____ Feeling unloved by others |
| _____ Feeling unloved by God | _____ Recurrent distressing dreams |
| _____ Sense of reliving traumatic events | _____ Delusions (unreasonable thoughts or beliefs) |
| _____ Do you hear or see things that others don't | _____ Physical abuse (past or current) |
| _____ Sexual abuse (past or current) | _____ Psychological abuse (emotional/verbal) |
| _____ Binging/compulsive overeating | _____ Intentional vomiting |
| _____ Use of diuretics or laxatives | |

RELIGIOUS BACKGROUND

Do you believe in God? If no, explain.

Are you a born-again Christian?

If yes, when is your spiritual birthday?

What is your denominational preference?

Do you regularly attend church now?

If so, where do you attend?

How often are you reading your bible?

What church did you attend as a child, if any?

Please describe your current walk with the Lord.

ALCOHOL/DRUG HISTORY

Do you drink alcoholic beverages? If so, how much and how often to you drink?

Have you or a family member ever been concerned about your alcohol usage?

Have you ever been concerned about another family member's alcohol usage?

If yes, who?

Do you have a history of illegal drug or prescription drug usage?

Have you ever been concerned about another family member's illegal drug use or prescription drug use?

EMERGENCY INFORMATION

Who could we contact in case of an emergency?

Name and phone number: _____

Name and phone number: _____