

Counseling Center at Charlotte

SUPPLEMENTAL INFORMATION

Please provide the below information as it helps me learn about you more quickly.

WHAT BRINGS YOU TO COUNSELING?

PLEASE BRIEFLY DESCRIBE YOUR REASON FOR SEEKING HELP:

WHAT WOULD YOU LIKE TO SEE HAPPEN AS A RESULT OF COUNSELING?

PLEASE PUT A CHECK BY ANYTHING BELOW YOU HAVE EXPERIENCED IN THE LAST THREE MONTHS:

BEHAVIORS	FEELINGS	PHYSICAL CONDITIONS	THOUGHT PROCESSES
☐ Explosive anger	☐ Feel numb inside	☐ Always tired	☐ Suicidal thoughts
☐ Withdrawal	☐ Feeling irritable	☐ Poor appetite	☐ Racing thoughts
☐ Indecisive	☐ Feeling fearful	☐ Trouble sleeping	☐ Seeing things others do not
☐ Impatient	☐ Feeling inferior or worthless	☐ Loss of weight	☐ Always worried
☐ Don't like being alone	☐ Feeling anxious, nervous a lot	☐ Weight gain	☐ Paranoid thoughts
☐ Difficulties at work	☐ Feeling angry often	☐ Dizziness	☐ Nightmares
☐ Impulsive	☐ Feeling like others are conspiring against you	☐ Shaky hands	☐ Worried about health
☐ Can't concentrate	☐ Feel like smashing things	☐ Stomach trouble	☐ No one understands me
☐ Easily excited	☐ Feel like hurting someone	☐ Frequent headaches	☐ Hearing voices inside head
☐ Difficulties in relationships	☐ Feeling easily hurt	☐ Fainting spells	☐ Experiencing flashbacks
☐ Very restless	☐ Not enjoying things	☐ Muscles twitching or jumping	☐ Out of body experiences
☐ Full of energy	☐ Feeling lonely	☐ Chest feels tight	☐ Repetitive obsessive behaviors or thoughts
☐ Crying spells	☐ Grieving	☐ Fast heartbeat	☐ Debilitating fears
☐ Unable to have fun	☐ Feeling panicky	☐ Frequent sweating	☐ Confused easily
☐ Unable to pray	☐ Lacking confidence	☐ Nausea or vomiting	☐ Feel like in a fog
☐ Unable to relax	☐ Afraid of going out	☐ Lack of energy	☐ Believe being watched
☐ Repetitive compulsive behaviors	☐ Feeling tense	☐ Cold feet and hands	
☐ Spending a lot of money	☐ Depressed	☐ Often feel sick	
☐ Strange sexual urges	☐ Feeling guilty	☐ Sexual problems	
☐ Cutting or hurting self	☐ Feeling confused	☐ Muscle aches	
	☐ Feeling hopeless	☐ Pain down arms	
		☐ Joint/back problems	

PLEASE LIST ANY DEATHS, SIGNIFICANT LOSSES, AND/OR TRAUMAS WITH DATES, AND ANY RECENT MAJOR TRANSITIONS:

IS THERE ANYTHING ELSE THAT WOULD BE HELPFUL FOR YOUR THERAPIST TO KNOW?

RELATIONSHIP AND FAMILY HISTORY

ARE YOU CURRENTLY: ☐ SINGLE ☐ DATING ☐ LIVING WITH SIGNIFICANT OTHER ☐ ENGAGED ☐ MARRIED
☐ SEPARATED ☐ SPOUSE/PARTNER DECEASED – IF SO, WHEN? _____

SPOUSE/PARTNER'S NAME _____ **PHONE** _____ **AGE** _____
OCCUPATION _____ **EMPLOYER** _____

PLEASE LIST ANY PAST SIGNIFICANT RELATIONSHIPS BY APPROXIMATE DATE(S) OF YOUR:

MEETING	LIVING TOGETHER	MARRIED	SEPARATED	DIVORCED	PARTNER'S DEATH

PLEASE LIST ANY CHILDREN:

NAME	DATE OF BIRTH	LIVING?	AGE	SEX	MARITAL STATUS	SCHOOL OR CITY OF RESIDENCE

FAMILY OF ORIGIN: *(complete this section about persons you think of as your...)*

FATHER: *(circle one)* BIRTH STEP ADOPTIVE FOSTER OTHER

STILL LIVING? YES NO DATE OF DEATH _____

CURRENT AGE OR AGE AT DEATH _____

USUAL (OR FORMER) OCCUPATION _____

CURRENT PLACE OF RESIDENCE _____

EDUCATION COMPLETED _____

RELIGIOUS PREFERENCE _____

MOTHER: *(circle one)* BIRTH STEP ADOPTIVE FOSTER OTHER

STILL LIVING? YES NO DATE OF DEATH _____

CURRENT AGE OR AGE AT DEATH _____

USUAL (OR FORMER) OCCUPATION _____

CURRENT PLACE OF RESIDENCE _____

EDUCATION COMPLETED _____

RELIGIOUS PREFERENCE _____

ARE YOUR PARENTS STILL TOGETHER? ☐ YES ☐ NO IF THEY WERE DIVORCED WHAT WAS YOUR AGE AT THAT TIME? _____

WOULD YOU RATE YOUR PARENTS' MARRIAGE AS: ☐ VERY HAPPY ☐ HAPPY ☐ AVERAGE ☐ UNHAPPY ☐ VERY UNHAPPY

WOULD YOU RATE YOUR CHILDHOOD LIFE AS: ☐ VERY HAPPY ☐ HAPPY ☐ AVERAGE ☐ UNHAPPY ☐ VERY UNHAPPY

AS A CHILD DID YOU FEEL CLOSER TO: ☐ YOUR FATHER ☐ YOUR MOTHER ☐ ANOTHER _____

PLEASE LIST YOUR BROTHERS AND SISTERS IN BIRTH ORDER

NAME	AGE	LIVING?	SEX	MARITAL STATUS	SCHOOL OR CITY OF RESIDENCE

FAITH/SPIRITUAL BACKGROUND

THE FOLLOWING QUESTIONS ARE NOT NECESSARY TO FILL OUT BUT CAN BE HELPFUL INFORMATION FOR YOUR COUNSELOR TO HAVE. THERE IS NO PRESUMPTION ABOUT OR JUDGEMENT OF ANY PERSON'S SPIRITUAL LIFE.

IF ACTIVE IN A PLACE OF WORSHIP (OF ANY FAITH) :

DO YOU BELIEVE IN GOD? ☐YES ☐NO ☐UNCERTAIN

IF YOU HAVE ONE, WHAT FAITH TRADITION AND/OR DENOMINATION IS YOUR PLACE OF WORSHIP? _____

IF YOU ATTENDED A CHURCH IN CHILDHOOD, WHAT WAS IT? _____

HAVE YOU EVER FELT BETRAYED OR SERIOUSLY HURT BY A PASTOR OR OTHER RELIGIOUS LEADER ☐YES ☐NO

ARE THERE ANY SPIRITUAL CONCERNS OF WHICH YOU WOULD LIKE YOUR THERAPIST TO BE AWARE? _____

PHYSICAL/MEDICAL INFORMATION

RATE YOUR PHYSICAL HEALTH: ☐GOOD ☐AVERAGE ☐POOR

HEIGHT _____ WEIGHT _____

RECENT WEIGHT CHANGE: LOST: _____ LBS. GAINED _____ LBS.

LIST IMPORTANT PRESENT OR PAST ILLNESSES OR INJURIES (*include any hospitalizations and dates*)

DATE OF LAST MEDICAL EXAMINATION _____ PHYSICIAN'S NAME _____

YOUR REGULAR (PRIMARY CARE) PHYSICIAN IF DIFFERENT _____

ARE YOU PRESENTLY TAKING ANY PRESCRIPTION MEDICATION? ☐YES ☐NO WHAT AND HOW MUCH _____

DO YOU SMOKE ☐YES ☐NO IF SO, HOW MUCH? _____

DO YOU DRINK ALCOHOL? ☐YES ☐NO IF SO, HOW MUCH? _____

DO YOU USE OTHER SUBSTANCES AND IF SO WHAT, HOW MUCH AND HOW OFTEN? _____

ANY COMPULSIVE BEHAVIOR _____

HAVE YOU EVER BEEN TREATED OR SEEN BY A PSYCHIATRIST? ☐YES ☐NO WHEN? _____

NAME: _____ APPROXIMATE NUMBER OF SESSIONS _____

NAME: _____ APPROXIMATE NUMBER OF SESSIONS _____

HAVE YOU EVER BEEN TREATED OR SEEN BY ANOTHER COUNSELOR? ☐YES ☐NO WHEN? _____

NAME: _____ APPROXIMATE NUMBER OF SESSIONS _____

NAME: _____ APPROXIMATE NUMBER OF SESSIONS _____