

Center Point

The following form will become part of your confidential record. Please answer each question as completely and carefully as you can.

Name: _____ Date of Birth: _____ Age: _____ Sex: _____
 Address: _____ County: _____

If a minor: Mother's Work and Phone: _____
 Father's Work and Phone: _____
 Emergency Contact: _____

Employment Background Are you currently employed? Yes No
 Employer's Name: _____
 Type of Work / Position: _____ Length of time: _____

Personal Information
 Who referred you to our office? _____
 May we send them a letter of thanks? _____
 Describe any physical problems you have that require medication or physical care: _____

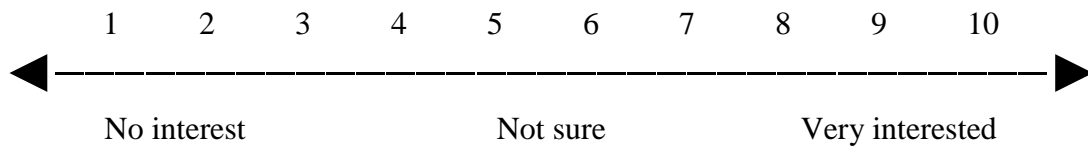
How long ago was you last physical? _____
 Are you currently receiving medical treatment? Yes No
 If yes, please explain: _____

Are you currently taking any prescription medication? Yes No
 If yes, please list: _____

SPIRITUAL BACKGROUND

What local church do you attend? _____ How frequently? _____

How would you rate your current interest in spiritual growth?



Problem Areas

Place a check mark next to each item that identifies an area of concern to you. Place two checks next to those that are most important. Feel free to add additional comments.

- | | |
|---|--|
| <input type="checkbox"/> I have no problem or concern | <input type="checkbox"/> Oversensitivity to rejection/criticism, shyness |
| <input type="checkbox"/> Abuse-physical, sexual, emotional, neglect (of children or elderly), cruelty to animals | <input type="checkbox"/> Headaches, other kinds of pains |
| <input type="checkbox"/> Aggression, violence, threats | <input type="checkbox"/> Gambling |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Fears, phobias, suspiciousness |
| <input type="checkbox"/> Anxiety, nervousness, panic, tension | <input type="checkbox"/> Fatigue, tiredness, low energy |
| <input type="checkbox"/> Anger / Frustration, hostility, arguing, irritability, temper problems, self-control | <input type="checkbox"/> Failure |
| <input type="checkbox"/> Career concerns, goals, choices, school | <input type="checkbox"/> Emptiness |
| <input type="checkbox"/> Children, child management, child care, parenting, custody of children | <input type="checkbox"/> Guilt |
| <input type="checkbox"/> Codependence | <input type="checkbox"/> Sleep disturbances-too much/little, insomnia |
| <input type="checkbox"/> Confusion, thought disorganization | <input type="checkbox"/> Irresponsibility |
| <input type="checkbox"/> Depression, low mood, sadness, crying | <input type="checkbox"/> Thoughts of hurting yourself |
| <input type="checkbox"/> Education | <input type="checkbox"/> Thoughts of hurting others |
| <input type="checkbox"/> Eating difficulties-overeating, under eating, appetite disturbance, vomiting, weight, diet | <input type="checkbox"/> Isolation / withdrawal |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Drug use-prescription, over-the-counter, street |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Use of alcohol by family member / other |
| <input type="checkbox"/> Marital problems, conflict, distance/coldness, infidelity/affairs, remarriage | <input type="checkbox"/> Work / career |
| <input type="checkbox"/> Physical problems, health, illness | <input type="checkbox"/> Unpleasant thoughts won't go away |
| <input type="checkbox"/> Social relationships, interpersonal conflicts | <input type="checkbox"/> Obsessive / compulsive behavior, compulsions |
| <input type="checkbox"/> Impulsiveness, lack of control | <input type="checkbox"/> Easily agitated / annoyed |
| <input type="checkbox"/> Grieving, mourning, deaths, losses, divorce | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Judgment problems, risk taking | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Legal matters | <input type="checkbox"/> Difficulty trusting |
| <input type="checkbox"/> Problems with parents | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Low energy, motivation, laziness | <input type="checkbox"/> Sadness |
| <input type="checkbox"/> Low self-esteem, inferiority feelings | <input type="checkbox"/> Stress, tension |
| <input type="checkbox"/> Poor concentration, attention, distractibility | <input type="checkbox"/> Heart pounding / racing |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Worthlessness | <input type="checkbox"/> Trembling / shaking |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Financial or money troubles, debt, impulsive spending, low income |
| | <input type="checkbox"/> Friendships |
| | <input type="checkbox"/> Menstrual problems, PMS, menopause |
| | <input type="checkbox"/> Mood swings |

I have read the information sheet voluntarily.

Signature: _____ Date: _____

For clients 17 and under, the signature of his / her guardian or custodial parent is required.

Signature: _____ Date: _____