Agape Christian Counseling Center

New Client Questionnaire

Today's Date:_____

Client Name:_____ _____ _____
First *Middle* *Last*

Preferred Name: _____ Date of Birth: _____ Age:_____

Address 1: _____

Address 2:_____

Zip:_____ City/State: _____

Mobile Phone: _____ May We Leave a Message at This Number?_____

Home Phone:_____ May We Leave a Message at This Number?_____

Work Phone:_____ May We Leave a Message at This Number?_____

Other Phone:_____ May We Leave a Message at This Number?_____

Administrative Sex:_____ Gender Identity:_____

Sexual Orientation:_____ Race:_____

Language(S):_____

Marital Status:_____

Referral Status:_____

Employment:_____

HISTORY OF PRESENT PROBLEM::

Presenting Problems:	When It Started:	How Often:
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____

SYMPTOMS CHECKLIST:

Rate intensity of symptoms experienced in last week to previous 3 months.

0= NONE: not present
1=MILD: impacts quality of life but doesn't affect daily functioning
2=MODERATE: significant impact on quality of life and/or daily functioning
3=SEVERE: debilitating impact across all areas of life

_____ Anxiety	_____ Irritability	_____ Poor Body Image
_____ Hopelessness	_____ Inattentiveness	_____ Panic Attacks
_____ Change In Sleep	_____ Binging/Purging	_____ Restlessness/Hyperactivity
_____ Outbursts Of Anger	_____ Excessive Spending	_____ Depressed Mood
_____ Social Isolation	_____ Weight Gain/Loss	_____ Losing Track Of Time
_____ Guilt	_____ Persistent Worry	_____ Poor Concentration
_____ Worthlessness	_____ Mood Swings	_____ Fatigue/Low Energy
_____ Self-Harm Behaviors	_____ Nausea, Diarrhea, Etc.	_____ Decrease In Grooming
_____ Suicidal Thoughts	_____ Obsessions/Compulsions	_____ Oppositional Behaviors
_____ Thoughts Of Hurting Others	_____ Delusions Or Hallucinations	_____ Loss Of Interest In Activities

GOALS FOR COUNSELING:

1)_____

2)_____

3)_____

PAST PSYCHIATRIC HISTORY:

Indicate previous counseling (Outpatient, Inpatient, Rehabilitation Facility)

1)Person/Facility Name:_____ Dates Seen:_____
Reason for Counseling:_____ ☐Outpatient ☐Inpatient ☐Rehab Facility

2)Person/Facility Name:_____ Dates Seen:_____
Reason for Counseling:_____ ☐Outpatient ☐Inpatient ☐Rehab Facility

3)Person/Facility Name:_____ Dates Seen:_____
Reason for Counseling:_____ ☐Outpatient ☐Inpatient ☐Rehab Facility

PreviousDiagnoses:_____
Dates & Method of Suicide Attempts:_____
Dates & Type of Self-
Harm:_____
Dates & Type of Violent Behaviors:_____
Past Abuse/Trauma (Events/Dates/Persons Involved):_____
_____
_____

TRAUMA HISTORY:

List nature of trauma, when occurred, persona involved, etc.)

1)Nature of Trauma:_____ Dates Occurred:_____
Person(s)Involved:_____

2)Nature of Trauma:_____ Dates Occurred:_____
Person(s)Involved:_____

3)Nature of Trauma:_____ Dates Occurred:_____
Person(s)Involved:_____

FAMILY PSYCHIATRIC HISTORY:

Indicate immediate family member's name, relation to you, and reason for counseling, psychiatric hospitalization, and/or rehab facility.

_____
_____
_____

MEDICAL CONDITIONS & HISTORY:

List current and past medical conditions, treatments, allergies, etc.

_____

_____

_____

CURRENT MEDICATIONS:

List name, dosage, purpose, prescribing physician, and date of next appt.

_____

_____

_____

SUBSTANCE USE:

List name, start date, end date(if applicable), amount, frequency of use (Include alcohol, cigarettes, vaping, illicit drugs, gambling, excessive media(phone/tv/Internet), adult material, etc.).

_____

_____

_____

FAMILY HISTORY:

Describe family of origin. This includes parents, step-parents, siblings, and persons that lived with you. List name, relation to you, current age, & quality of relationship (examples: positive, conflictual, distant).

_____

_____

_____

Family Substance Abuse/Addictions: *List who, start date, end date, amount, frequency of use, and impact on you.*

_____

_____

_____

SOCIAL HISTORY:

List significant relationships, social support, nature/quality of relationships, current Living Arrangements: Write name, relation to you, age.

DEVELOPMENTAL HISTORY:

Indicate developmental milestones, delays, etc.

EDUCATIONAL/OCCUPATIONAL HISTORY:

List level of education, current/past employment, etc.

LEGAL HISTORY:

List arrest history, sentencing, DUI occurrences, incarceration, and any litigation.

STRENGTHS/LIMITATIONS:

OTHER INFORMATION:

FILL OUT PAGE 6 IF CLIENT IS A MINOR, OR PAGE 5 FOR RELATIONSHIP COUNSELING.

CHILD/ADOLESCENT SECTION:

Three things you enjoy about school: _____

Three things that irritate you about school: _____

What do you hope to do for a career?_____

Who do you consider your closest friend? Why?_____

Would you consider yourself more of a leader or more of a follower? _____

Have you ever been bullied? By whom? How?_____

_____

Have you ever bullied someone? How? _____

_____

What is FUN? List things you most enjoy doing with free time. _____

_____

How well do you sleep? _____ How long do you sleep on average?_____

Describe any nightmares or recurring dreams: _____

_____

Any fears or worries? _____

Any thoughts or behaviors you repeat over and over again? _____

_____

Emotional Relationships: Describe & Rate on a scale of 1 to 10 (10 is high).

How close are you with your Mother? _____ Father?_____

If applicable, how close are you with Step-Parents? _____

How close are you with your siblings? Describe & Rate:_____

_____

Describe other close relationships:_____

_____

Who are you closest to and why?_____

Best thing that has happened in your life?_____

_____

Worst thing that has happened in your life?_____

_____

If you could change anything, what would it be?_____

_____

RELATIONSHIP COUNSELING SECTION: Wedding Date (if applicable) _____ / _____ / _____

Dating Narrative: How did you two get together? How well were you and your partner received by the? other person's family?_____

_____

Family of Origin Narrative: What was your parents' marriage like? How did they communicate feelings & resolve conflict? Who/How did they discipline the kids? Anything missed from parents that you needed?

_____

_____

_____

Relationship Narrative: When was the relationship good? Why? When did it begin to change? Why?

_____

_____

_____

What is your communication like (stating needs, listening, disagreeing, expressing anger, apologizing)?

_____

_____

_____

Sex: Who initiates, how do you discuss needs/desires, any past or present abuse, any other issues?

_____

_____

Money: Who handles it? How? How was this decided? Rate 1-10 (10 is high) each's handling of money.

_____

_____

Spirituality: In what ways are you and your partner similar or different in your spiritual beliefs?

_____

_____

Parenting Narrative: Parenting styles? In what ways is parenting an issue in your relationship?

_____

_____

Major Emotional Events? (ex. miscarriages, abortions, accidents, illnesses, deaths) What has been the effect on you & the relationship? _____

_____

_____