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?**

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**please put a check by anything below you have experienced in the last three months:**

behaviors

* Explosive anger
* Withdrawal
* Indecisive
* Impatient
* Don’t like being alone
* Difficulties at work
* Impulsive
* Can’t concentrate
* Easily excited
* Difficulties in relationships
* Very restless
* Full of energy
* Crying spells
* Unable to have fun
* Unable to pray
* Unable to relax
* Repetitive compulsive

behaviors

* Spending a lot of money
* Strange sexual urges
* Cutting or hurting self

feelings

* Feel numb inside
* Feeling irritable
* Feeling fearful
* Feeling inferior or worthless
* Feeling anxious, nervous a lot
* Feeling angry often
* Feeling like others are conspiring against you
* Feel like smashing things
* Feel like hurting someone
* Feeling easily hurt
* Not enjoying things
* Feeling lonely
* Grieving
* Feeling panicky
* Lacking confidence
* Afraid of going out
* Feeling tense
* Depressed
* Feeling guilty
* Feeling confused
* Feeling hopelessphysical conditions
* Always tired
* Poor appetite
* Trouble sleeping
* Loss of weight
* Weight gain
* Dizziness
* Shaky hands
* Stomach trouble
* Frequent headaches
* Fainting spells
* Muscles twitching or jumping
* Chest feels tight
* Fast heartbeat
* Frequent sweating
* Nausea or vomiting
* Lack of energy
* Cold feet and hands
* Often feel sick
* Sexual problems
* Muscle aches
* Pain down arms
* Joint/back problemsthought processes
* Suicidal thoughts
* Racing thoughts
* Seeing things others do not
* Always worried
* Paranoid thoughts
* Nightmares
* Worried about health
* No one understands me
* Hearing voices inside head
* Experiencing flashbacks
* Out of body experiences
* Repetitive obsessive behaviors or thoughts
* Debilitating fears
* Confused easily
* Feel like in a fog
* Believe being watched

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_