COLORADO MIND & BODY COUNSELING LLC

Adult History/Information

Welcome! I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to fill out this form. The information will help me better understand your situation as well as potential solutions in helping you get your life back on track. Please note - the information is confidential and will not be released to anyone without your written permission.

Sources of Stress

Please list the reasons that bring you here today. This may include certain problems, issues, significant losses or changes that are causing you problems.

1. _____

2. _____

3. _____

4. _____

Adult Strength Scale

Please circle the areas below that apply to you

Home

1. I feel part of the family	Never	Just a little	Pretty Much	Very Much	N/A
2. I am physically healthy	Never	Just a little	Pretty Much	Very Much	N/A
3. I have an enjoyable social life	Never	Just a little	Pretty Much	Very Much	N/A
4. I feel accepted by others	Never	Just a little	Pretty Much	Very Much	N/A
5. I am a good father/mother	Never	Just a little	Pretty Much	Very Much	N/A
6. I participate in decision making	Never	Just a little	Pretty Much	Very Much	N/A
7. There has been violence in the home	Never	Just a little	Pretty Much	Very Much	N/A

Comments: _____

_____

Marriage/Significant Other

1. I have considered divorce	Never	Just a little	Pretty Much	Very Much	N/A
2. I get along with my spouse	Never	Just a little	Pretty Much	Very Much	N/A
3. My spouse has been violent	Never	Just a little	Pretty Much	Very Much	N/A
4. My spouse and I can solve conflicts	Never	Just a little	Pretty Much	Very Much	N/A
5. I feel understood by my spouse	Never	Just a little	Pretty Much	Very Much	N/A
6. Our sexual relationship is satisfying	Never	Just a little	Pretty Much	Very Much	N/A
7. Affairs are a concern in our relationship	Never	Just a little	Pretty Much	Very Much	N/A

Comments: _____

_____

Work

1. I get to work on time	Never	Just a little	Pretty Much	Very Much	N/A
2. I get along with my co-workers	Never	Just a little	Pretty Much	Very Much	N/A

3. I am respected by my co-workers	Never	Just a little	Pretty Much	Very Much	N/A
4. I am respected by my supervisor(s)	Never	Just a little	Pretty Much	Very Much	N/A
5. I enjoy working	Never	Just a little	Pretty Much	Very Much	N/A
6. I have realistic career goals	Never	Just a little	Pretty Much	Very Much	N/A
7. I am a hard worker	Never	Just a little	Pretty Much	Very Much	N/A
8. I balance home and work	Never	Just a little	Pretty Much	Very Much	N/A

What are your current job duties; for how long?_____

Comments: _____

Emotional

1. I cope well with frustration	Never	Just a little	Pretty Much	Very Much	N/A
2. I cope well with disappointment	Never	Just a little	Pretty Much	Very Much	N/A
3. I use anger constructively	Never	Just a little	Pretty Much	Very Much	N/A
4. I am satisfied with life	Never	Just a little	Pretty Much	Very Much	N/A
5. I accept responsibilities for my mistakes	Never	Just a little	Pretty Much	Very Much	N/A
6. I drink (alcohol) responsibly	Never	Just a little	Pretty Much	Very Much	N/A
7. I can take constructive criticism	Never	Just a little	Pretty Much	Very Much	N/A
8. I think before I act	Never	Just a little	Pretty Much	Very Much	N/A
9. I have good self-esteem	Never	Just a little	Pretty Much	Very Much	N/A
10. I have used drugs to help me cope	Never	Just a little	Pretty Much	Very Much	N/A
11. I have considered suicide	Never	Just a little	Pretty Much	Very Much	N/A

Comments: _____

_____

Social

1. I make and keep friends	Never	Just a little	Pretty Much	Very Much	N/A
2. I am open to new ideas	Never	Just a little	Pretty Much	Very Much	N/A
3. I am considerate of others	Never	Just a little	Pretty Much	Very Much	N/A
4. I stand up for myself	Never	Just a little	Pretty Much	Very Much	N/A
5. I show leadership	Never	Just a little	Pretty Much	Very Much	N/A
6. I am able to compromise	Never	Just a little	Pretty Much	Very Much	N/A
7. I am comfortable around others	Never	Just a little	Pretty Much	Very Much	N/A
8. I get along with others	Never	Just a little	Pretty Much	Very Much	N/A
9. People can trust me	Never	Just a little	Pretty Much	Very Much	N/A
10. I am in trouble with the law	Never	Just a little	Pretty Much	Very Much	N/A

10.What do you do for recreation/leisure? _____

Comments:_____

_____

Attention

1. I cope with external distraction	Never	Just a little	Pretty Much	Very Much	N/A
2. I maintain attention to tasks	Never	Just a little	Pretty Much	Very Much	N/A
3. I follow through on tasks	Never	Just a little	Pretty Much	Very Much	N/A

4. I am able to compromise	Never	Just a little	Pretty Much	Very Much	N/A

Comments: _____

_____

Spiritual/Faith

1. I attend church regularly	Never	Just a little	Pretty Much	Very Much	N/A
2. Prayer is important to me	Never	Just a little	Pretty Much	Very Much	N/A
3. I am confident in my spiritual beliefs	Never	Just a little	Pretty Much	Very Much	N/A
4. My spiritual life is helpful to me	Never	Just a little	Pretty Much	Very Much	N/A

5. Religious Affiliation in Childhood_____ Currently_____

Problems That You Are Struggling With

Please check (X) those that apply to you.

( ) Depression

( ) Anxiety or panic attacks

( ) Suicidal thoughts or actions

( ) Blended family problems

( ) Brother/sister problem

( ) Violence in family-actual or threatened

( ) Sexual problem

( ) Employment issues

( ) Legal problems

( ) Compulsive gambling

( ) Death of a loved one

( ) Financial problems

( ) Cultural issues

( ) Life transition problem

( ) Alcohol/Drugs: If yes please indicate details:

( ) Parent-child conflict (self)

( ) Parent-child conflict (spouse)

( ) Marital/relationship problems

( ) Divorce issues

( ) Anger/temper problems

( ) Job/school problem

( ) Sexual Abuse – Adult or Child

( ) Low self - esteem

( ) Eating problems

( ) Major losses/difficult changes

( ) Communication problems

( ) Spiritual problem

( ) Struggling with a disability

( ) Medical Problems

( ) Gambling

Substance	Date last used	Amount	Frequency	# of years used

_____

_____

Current Symptoms

Please check (X) those that apply to you

( ) Sleep problems
- ( ) Difficulty falling asleep
- ( ) Waking in the middle of the night
- ( ) Waking too early
- ( ) Sleeping to much
- ( ) Nightmares

( ) Moody or crying more than usual
( ) Difficulties concentrating
( ) Problems remembering things
( ) Withdrawing from others
( ) Repeated actions I can't stop
( ) Can't stop washing hands/body, counting or checking things
( ) People picking on me
( ) Self-harm
- ( ) I cut myself
- ( ) I burn myself
- ( ) Other _____

( ) Change in appetite
- ( ) Gaining weight (specify _____)
- ( ) Losing weight (specify _____)
- ( ) Not hungry or not eating
- ( ) Throwing up after eating
- ( ) Feeling sick to my stomach

( ) Constipation or diarrhea
( ) Feeling guilty, worthless, or hopeless
( ) Fatigue/low energy
( ) Hyper/too much energy
( ) Loss of interest in things
( ) Disturbing thoughts I can't stop
( ) Low self esteem
( ) Hallucinations
- ( ) I hear things that are not real
- ( ) I see things that are not real
- ( ) I smell things that are not real
- ( ) I feel things that are not real

List Any Previous Suicide Attempts (if none, write "None")

When Method

_____

_____

List Previous Inpatient Psychiatric and/or Drug-alcohol Rehab. Hospitalizations (if none, write "None")

Dates (from-to) Reason

_____

_____

_____

Previous or Current Counseling (if none, write "None")

Therapist or Agency From/to Focus of Sessions

_____

_____

_____

What was helpful and/or not helpful about your previous/current counseling experience? _____

_____

What are your medical problems (current or past)? _____

_____

Current medication (s) you regularly take –
please include prescription, over the counter, and any herbal remedies (if none, write "None")

Name of Medication	Dosage	How often/day

Are You Allergic to Any Drugs (Please List)? _____

Are you currently on probation? Have you ever been in jail or prison? (if yes, please explain)

_____

_____

Family Information

Please list the people that you currently live with

Name	Relationship	Age

Do you have other children not living with you? If yes, please give names and ages_____

_____

Does your family have any psychiatric or substance abuse history? (please list)_____

_____

Does your family have a history of major health problems? (please list) _____

_____

What is your relationship like with your parents (past and current)? _____

_____

How would you describe your cultural background?

_____

_____

Please list family, friends, support groups and community groups that are helpful to you

_____

_____

_____

Have you ever been in the military? If yes, please provide details _____

_____

Are you a student? YES / NO What is your highest level of your schooling? _____

Are there any guns or weapons in your house? (please list) _____

_____

Current Functioning

Please place an "X" on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can considering your situation.

( ) 10% ( ) 20% ( ) 30% ( ) 40% ( ) 50% ( ) 60% ( ) 70% ( ) 80% ( ) 90% ( ) 100%

Your Goals in Counseling

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1._____

2._____

3._____

How Many Sessions Do You Think You Will Need To Get Back On Track?

Please place an (X) in the answer which best describes your expectations.

( ) 1-3 sessions ( ) 4-6 sessions ( ) 7-9 sessions ( ) 10-12 sessions ( ) Other (please specify): _____

Thank you for taking the time to complete this information