CONFIDENTIAL

221 E. Crawford Street

Elkhart, IN 46514, (574) 262-3597

Initial Questionnaire

Name:____Date:__________________

Age:______ Birth:_____/_____/________ Sex: ____M ____F Mobile #: :(____)______ - ____________

Address:____ Home #:(____)______ - ____________

City:____________________ State:____ Zip:___________Work #:(____)______ - __________Ext._____

Your Occupation:___________________________ Employer's Name:_____________________________

Last grade completed: 1 2 3 4 5 6 7 8 (Grade School) 9 10 11 12 (High School) 1 2 3 4 (College) 5 6 7 8+ (Graduate School)

If you currently attend school, give its name and location:____

Relationship Status: Single Partnered Married Separated Divorced Widowed

Partner/Spouse's Name:________________________________

Do you have any children?____Yes ____No If so, how many?______ Age(s)?__________________

Have you participated in military service? ___Yes ___No Combat Service? ___Yes ___ No

Dates:___________________ Branch:_____________________Discharge Status:__________________

If Minor Name of Mother: _________________________________ live with ____Yes _____No

Address if different from above:____

Mother's DOB_____________________________

If Minor Name of Father___________________________________live with _____Yes_____No

Father's DOB______________________________

Address if different from above____

Siblings Names and ages:____

____

____

How did you hear about The Samaritan Center: ____________________________

Are you being required to seek counseling? __Yes ___No If so, by whom?__________________________

Have you had other counseling or psychotherapy? ___Yes ___No

From________ To________ Approx. # of Sessions_____ Name/Organization:_____________________

From________ To________ Approx. # of Sessions_____ Name/Organization:_____________________

From________ To________ Approx. # of Sessions_____ Name/Organization:_____________________

	Poor	Fair	Avg.	Good	Excellent
Your physical condition is:	☐	☐	☐	☐	☐
Your emotional condition is:	☐	☐	☐	☐	☐
Your spiritual condition is:	☐	☐	☐	☐	☐

CURRENT NEEDS/CONCERNS

What are your primary reasons for seeking counseling?____

____

How long have these problems existed?____

Since they started, have your problems: ____Stayed the same? ____Improved? ____Worsened?

What do you feel are the causes of your problems?____

Please indicate concerns that apply to you:

__ Bereavement (grief)	__ Illness of self or other person	__ Loss of faith in self
__ Depression	__ Problems at work	__ Loss of faith in others
__ Anxiety	__ Fear	__ Loss of hope or meaning
__ Panic	__ Intense anger	__ Loss of self-respect
__ Vocational direction	__ Insecurity/Self Doubt	__ Loss of love
__ Problems at School	__ Physical abuse	__ Religious doubts and fears
__ Nervousness or Shakiness	__ Guilt	__ Anger with God
__ Marriage/Partner problems	__ Impulse control	__ Loss of faith in God
__ Sexual concerns	__ Unusual feelings	__ Sleeplessness
__ Sexual abuse	__ Suicidal feelings/thoughts	__ Troubled Dreams
__ Infidelity of self or partner	__ Relationship w/ parents/in-laws	__ Alcohol/Drugs
__ Impotency/Frigidity	__ Relationship w/ children	__ Codependence

__Other____

What are the problems you want to work on in therapy?____

Your problems would improve if:____

Do you believe that you can be helped? __Yes __No

What would you like your life to be like five years from now?____

____

(Check or Circle) **Please rate these statements**:	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I feel good about myself:	□	□	□	□	□
I can deal with my problems:	□	□	□	□	□
I am able to maintain control in my life:	□	□	□	□	□

In the last 30 days, to what extent have the problems which lead you to seek help interfered with your:

	None	A Little	Somewhat	A Lot	Extremely
Family Life:	□	□	□	□	□
Social Life:	□	□	□	□	□
Work, schoolwork, or housework:	□	□	□	□	□
Health and Physical well-being:	□	□	□	□	□

In the last 30 days, how much has physical pain bothered you? None Some Moderate A lot Extremely

In the last 6 months, how many times have you seen a medical professional? Zero 1 2-3 4-5 More

Do you have a serious and/or chronic medical condition? If so, state:_____________________________________

Are you receiving, considering filing, or filed for disability benefits or worker's compensation? ___Yes ____No

Have you consumed alcohol or used drugs in the past 30 days? Alcohol?___Yes ___No Drugs?____Yes____No

Per time, how many drinks do you have?_____Do you feel guilt/criticized about drinking?____Yes____No

Are you involved in or considering any legal action which may affect your counseling? Yes__ No__

If yes, explain ____