Hope Crossing Christian Counseling, Inc.

*To be given to your therapist at your first visit. To better provide targeted services please complete to the best of your ability.

Client Name:_____ Date:____/____/____

Completed By: _____ (circle one) self parent/guardian spouse

Please give a brief description of your need for counseling:

_____

_____

_____

_____

Please mark those that apply and give a brief description of the problem:

____ Depression:_____

_____

____ Anxiety/Stress:_____

_____

____Appetite Changes:_____

_____

____ Sleep Changes:_____

_____

____ Concentration/Focus:_____

_____

____ Work/School Impairment:_____

_____

____ Ability to Care for Self:_____

_____

____ Ability to Care for Family/Home/Children:_____

_____

____ Family Conflicts:_____

_____

____ Compulsions/Addictions:_____

_____

____ Uncomfortable is Social Settings:_____

_____

____ Spiritual Problems:_____

_____

____ Feelings of Hopelessness/Despair:_____

_____

____ Suicidal Thoughts:_____

_____

____ Suicidal Attempts:_____

_____

____ Previous Counseling:_____

_____

____ Previous Hospitalization:_____

_____

____ Current Counseling:_____

_____

____ Other Pertinent Information:_____

_____

_____

_____

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