

Freedom Counseling
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Name: _____ Today's Date: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____

Social Security #: _____ Sex: _____

Church Affiliation: _____

Place of Employment: _____

Primary Care Physician: _____

Phone: _____

In Case of Emergency - Call:

Name: _____

Phone: _____

Referral Source (Please give name if appropriate):

Friend: _____

Doctor: _____

Phone Book: _____

Church: _____

Other: _____

Briefly describe why you sought therapy:

History of Personal Health

1. Describe your eating habits (that is, junk food addict, regular, sporadic, balanced diet, etc).
2. Do you have any addictions or cravings that you find difficult to control (sweets, drugs, alcohol, food in general, other)?
3. How much coffee, cola, tea or other sources of caffeine do you consume each day?
4. Do you feel you are overweight/underweight?
5. Do you attempt to restrict your diet in any way?
6. Do you have any trouble sleeping? Are you having recurring nightmares or disturbance? If so, briefly explain:
7. Does your present schedule allow for regular periods of rest and relaxation?
8. What kind of physical exercise do you get?
9. How would you describe your general, overall health?

Mental

1. Which of the following have you struggled with in the past or are you struggling with presently? (Please circle)

Daydreaming
Thoughts of inferiority
Worry
Fantasy
Insecurity
Compulsive thoughts
Headaches

Lustful thoughts
Thoughts of inadequacy
Doubts
Obsessive thoughts
Blasphemous thoughts
Dizziness

2. Do you struggle with repetitive or obsessive thoughts you have tried to overcome? (ex. – I'm stupid, I have to ...)

3. Do you spend much time wishing you were somebody else or fantasizing that you were a different person? Do you imagine yourself living at a different time, in a different place, or under different circumstances? Explain.

4. Do you compare yourself to others – if so, whom?

5. How many hours of TV do you watch a week? List your five favorite programs.

6. How many hours do you spend each week reading? What do you read primarily (newspaper, magazines, books, other).

7. Do you enjoy listening to music? List a few of your favorite groups and songs.

8. What other forms of media do you regularly view (theater, audio cd's, etc.)?

2. Describe any allergies you have:

To what?	Reaction you have	Allergy medications you take
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. List *all* medications or drugs you have taken in the last year – prescribed, over-the-counter, and others. (Use back if necessary).

Medication/drug	Dose (how much)	Taken for	Prescribed/supervised by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

5. Previous Mental Health Treatment:

Therapist or Hospital	Type (Ind., group, etc)	Length of treatment	Date of last visit
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Please name any other programs you have tried in the last five years (self-help groups, recovery groups, etc.).

For Women only

1. At what age did you start to menstruate (get your period)?

2. Menstrual period experiences:

- A. How regular are they? _____
- B. How long do they last? _____
- C. How much pain do you have? _____
- D. How heavy are your periods? _____
- E. Other experiences during period? _____

3. Please list all of your pregnancies and explain what happened with each pregnancy:

Your age	Miscarriage/terminated	Child born	Date	Problems?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Menopause:

A. If your menopause has started. At what age did it start?

B. What signs or symptoms have you had?

5. Are there any other medical or physical problems for which you are concerned?

Family/ Social Relations

1. What are your usual living arrangements?

2. How long have you lived in these arrangements?

3. Are you satisfied with these arrangements?

4. With whom do you spend most of your free time? Please check all that apply:

- Family Friends Co-workers Alone

5. What are a few of your favorite free time activities?

6. Have you had significant periods in which you have experienced serious problems getting along with any of the following?

Mother _____

Father _____

Siblings _____

Spouse/Partner _____

Children _____

Other
Family _____

Close
Friends _____

Neighbors _____

Co-
workers _____

7. Did these or any other people abuse you?

Emotionally (harsh words that really stuck) _____

Physically (cause you physical harm) _____

Sexually (forced sexual advances/acts) _____

8. How many days in the last 30 days have you experienced serious conflicts?

9. How troubled are you about these conflicts?

Comments:

Marital Background

1. Marital status, please check.

Single Married Divorced Separated Widowed Cohabiting

2. What is your spouse's name? _____ How long? _____

3. Briefly describe your relationship with your spouse:

4. Number of previous marriages?

How long? _____

How long? _____

How long? _____

how dissolved? _____

how dissolved? _____

how dissolved? _____

5. How many children living at home?

List names:

_____ age _____

_____ age _____

_____ age _____

_____ age _____

_____ age _____

From previous marriage with: (if applicable)

Comments:

Educational Information

1. Education/years completed? (GED = 12 yrs.) _____

2. Training/ technical education _____

3. Trade or skill _____

4. College/ University _____ Degree _____

Comments:

Occupation

1. Usual or last occupation _____

How long? _____ Have you worked in the last 30 days? _____

2. How long was your longest full-time job? _____

3. Have you ever been unemployed? _____ how long? _____

4. Reason for unemployment _____

5. Means of support while unemployed _____

Employment History:

Job	Years worked (FT or PT)	Reason for leaving
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Describe any problems on the job (past or present).

7. Driver's license? _____ Automobile available for use? _____

8. Does anyone else contribute to your support in any way? _____

9. Have you received any money from the following sources in the last 30 days?

Employment _____ Unemployment _____
Welfare _____ Pension benefits _____

Military service record

1. Have you ever been in the military service? Yes – Branch _____ No

2. Were you in combat? Yes No. In Vietnam? _____

3. Any military honors or medals? _____

4. Ever brought up on charges before a superior officer? If so, please explain.

5. Denied promotion or transferred because of charges?

6. Type of discharge? _____

7. Comments:

Legal History

1. Do you have any arrest charges pending?

2. Have you had previous arrests?

Charge	Date
_____	_____
_____	_____
_____	_____

3. Are you on probation? _____ Parole? _____

4. If on probation/parole, who is your officer? _____

What county? _____

5. Have you ever been incarcerated? _____

What for	How long	Where
_____	_____	_____
_____	_____	_____
_____	_____	_____

Comments:

