Client Number: _____

Office use only:
DSM-IV Code_____
Session Fee $_____

WELLSPRING COUNSELING

Adult Self-Report

Last Updated 07/16/04

The following questions are designed to gather information about you and your health. This information is voluntary and may aid in the identification of conditions that are relevant to the mental health services provided to you at WellSpring.

Counselor: _____ Date: _____

Client Name: _____ Client Birth Date: _____

Please list all persons living in client's current household (exclude self):

Last Name	First Name	Relationship to Client	Sex	Birth Date	Health Status

Please list all persons in client's family of origin(your family growing up) if different than current household:

Last Name	First Name	Relationship to Client	Sex	Birth Date	Health Status

Ethnic Group (pls. check): African Amer. ____; Cauc. ___; Oriental ____; Bi-racial ____; Native Amer. ____; Hispanic ____; Other ____

Military Service (pls. check): None ____; Veteran ____; Reserves ____; Active duty ____ - Branch of Service: _____

Education (pls. check): Grade 1-8 ___; Grades 9-12 ___; HS grad ___; Some college ____; College grad ____; Post-grad degree ____; Vocational or Tech. degree ____

Usual Occupation (pls. check): Administrative ____; Professional ____; Technician ____; Skilled labor ____; Laborer ____; Service ____; Student ____; Other _____

Client's Mental Health

Have you had any prior mental health counseling, evaluation, or treatment? ____yes___no
List and describe:

Agency Name	*Address*	*Phone*	*Therapist*	*Dates*

Have you ever been hospitalized for mental health treatment? _____yes ___no
Describe:_____
_____

Presenting Concern (What concern has brought you in for counseling?):
Take whatever space you need to describe in your own words the issue(s) which brings you in for counseling. Please feel free to go into detail regarding the related background or history of the concerns and the factors which have lead you to see a need for counseling. It might also be helpful to describe any and all persons past and present who are involved and their relationship to the issues. If you are able to identify a goal or goals for counseling, please do so as well. After completing this portion, please complete the remainder of this Self Report.

Client's Vocational History:

Was your vocation chosen? ____ If yes, why? _____
Were you forced into your present occupation? ____ If yes, under what circumstances?
_____
_____
Have you ever changed occupations? ____ If yes, why? _____
What would you want to be or do if you were not in your present vocation? _____
_____

Client's Marital History:

Current marital status: _____ _____ _____ _____ _____ _____
married single divorced widowed separated other
Date married? _____ Spouse's current age? _____
Spouse's occupation? _____
Ages you and spouse were when married? _____ _____
client spouse
Do you feel compatible with your spouse? _____ Why?_____
_____
Any miscarriages? __ If yes, how many? _____ Any abortions? ___ If yes, how many? ____
What is your general attitude toward children? _____

Please indicate previous marital history:

Ex-spouse's Name	Divorce, Dissolution, or Death	Date of Event	Reason Marriage Ended

Client's Present Physical Condition:

Height? _____ Weight? _____ Appetite? _____

Please check:

	Good	Fair	Poor
General Health			
Vision			
Hearing			

Effects of operations? _____

Any bowel/urinary malfunctions? _____
Any use of (pls. check): Alcohol? _____ Drugs? _____ Tobacco? _____ Caffeine? _____
Do you have any allergies? ____ No ____ Yes If yes, please list

Please list any prescribed medication that you are currently using:

Medication	Dosage/Frequency	Prescribing Doctor

Do you have any significant physical problems or limitations? ____ No ____ Yes If yes, please explain: _____
Personal physician's name, if applicable? _____
Approximately how long ago were you examined by your personal physician? _____

Client's Sexual Life:
At what age were you initially informed about sex? _____ By whom? _____
How was this done? _____
Engage in masturbation frequently? _____ yes _____ No
Any homosexual activity or homosexual thoughts? _____ Yes _____ No
How do you regard sex? _____
Any heterosexual activity outside of marriage? _____
Do you feel any conflict between your sexual behaviors and your Christian beliefs (only if client claims to be a Christian)? _____
What is your intercourse frequency? _____ Are you satisfied with the frequency? _____
Contraception used? _____ Any venereal disease history? _____
Menstruation history: age of first period? _____ Feelings associated with the onset? _____
Cycles regular? _____ Are they painful? _____ Suffer from PMS? _____

Client's Religious Life:

What role did religion play in your home life as a child? _____
_____
_____
Do you have any denominational ties? _____
What were your ideas of God when you were a child? _____
Were you taught to pray as a child _____
Are you a practicing Christian? ____ No ____ Yes (if no, disregard next section)

Client's Christian Belief System:

How did you become a Christian? _____
Do you pray regularly? ____ Yes ____ No Do you read the Bible regularly? ___ Yes ____ No
Do you feel that your Christianity has made you conscience too severe? _____
Do you suffer feelings of guilt? ____ Yes ____ No Are you fearful of hell? ____ Yes ____ No
Are you fearful of the unpardonable sin? __ Yes __ No Of not being forgiven? __ Yes __ No
Who is your favorite Bible character? _____ Why? _____
_____
What is your favorite Bible verse? _____
If you could ask God for three things, what would they be? 1.) _____
2.) _____ 3.) _____
What would you consider to be the worst sin a person could commit and why? _____
_____
What would you consider the most Christian deed a person could perform and why? _____
_____