ASHEVILLE CHRISTIAN COUNSELING

Dr. Will Cunningham, CTC, LCPC, BCPC

Initial Evaluation Form

Personal/Family Record:

To make our first visit more productive, please give accurate and complete information. This will help to make a determination of your need and how we may help you. Please use the reverse side to expound on any question or add your own thoughts.

Date____/____/____ Age _____ DOB _____

Full Name_____

Address_____City_____State_____ Zip_____

Phone (home)_____(work)_____

Email: _____

Employer_____

Position_____

Social Security # _____/_____/_____

Education: Grade Completed _____Degree_____

Marital Status: Never Married _____ Married_____ Divorced____ Separated_____ Widowed_____

Spouse's

1293 Hendersonville Rd. Building A, Suite 24
Asheville, NC. 28803
828-505-5079
Will@ashevillechristiancounseling.com **www.ashevillechristiancounseling.com**

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Name: _____
Occupation_____

I was referred by: _____

Ph# _____/_____/_____

Have you ever been in counseling/treatment before? _____If yes give details:

Name of counselor, pastor, doctor, treatment, etc
Purpose **Date(s)**

_____ _____

_____ _____

Presenting Problems:

_____

_____

Emotional History

_____ I don't remember being loved physically as a child (hugs, being held, etc)
_____ My parents divorced when I was a child. I was _____years old _____
I had no father growing up because of (circle one) death/divorce/preoccupation _____
One of my parents committed suicide. I was _____years old.

_____ I suffered abuse from a non-parental family member.

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Please identify the relationship: _____
_____ I was sexually abused as a child. By whom? _____ _____
I had (have) a physical/mental abnormality that brought ridicule from peers.
_____ I was verbally abused as a child.
_____ I have given up a child for adoption.
_____ I have had a very unhappy marriage.
_____ I had an alcoholic parent.
_____ I was adopted.
_____ I have felt abandoned by friends.
_____ I suffer from low self-esteem.
_____ I experienced a severe trauma (house fire, accident, tragedy)

Please explain_____

_____ I have had one or more abortions. How many? _____ When_____
_____ I have had one or more miscarriages. How many? _____ When_____

Alcohol/Drug History (type, route, frequency, pattern, periods of abstinence, first use, last use, gambling/eating/sexual/other addictive issues) **Please list ALL**

_____

_____

Legal Status: Are you currently on parole, probation, or ordered by the court to seek treatment? If yes, for how long and for what?

_____

Parole/Probation Officer

_____

Address_____Phone#_____

PLEASE NOTE: WE ARE NOT A MEDICAL FACILITY AND <u>CANNOT</u> GIVE MEDICAL CARE.
Emergency Contacts:

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_____

Address

_____

Phone # _____

Spiritual History

Because this practice is based on biblical values and principles, the following information will be helpful in our assessment.

Religious background in childhood (briefly describe)

_____

Church Affiliation _____

Member _____

Pastor's Name _____

Phone # _____

Are you a Christian? Yes_____ No_____ Uncertain _____

If yes, I consider myself to be: 1 2 3 4 5 6

Committed Detached

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Church involvement: 1 2 3 4 5 6
Very Active Detached

The following (may) indicate spiritual oppression. Please check any that relate)

_____ Desire for: Psychic abilities, clairvoyance, divination, feeling of having "special powers."

_____ Inward perception of a separate personality, or voice prompts undesirable behaviors.

_____ Fearful, repetitive night visitations by an evil presence
_____ Separation of mind from body – spacing out, dizziness
_____ Inability to focus on and retain Biblical truth
_____ Difficulty participating in prayer: agitation, nausea, anger, rebellion, etc
_____ Uncontrollable thoughts/impressions, sexual perversions, cursing violence
_____ Uncontrollable compulsive behaviors; sexual sin, anger, chemical indulgence
_____ Preoccupation with thoughts of death, despair, and hopelessness
_____ Uncontrollable, irrational, paralyzing fear
_____ Unusual, non-typical emotional expressions; laughter, sadness, crying anger _____
Extreme nervousness or negative reactions mentioning the name of Jesus

Rate the degree of stress/urgency for applicable areas ---- 1 (low) to 5 (high)

_____ Depression	_____ Chronic Illness	_____ Sexual Identity Problems
_____ Marital Problems	_____ Anxiety/Fear	_____ Loneliness
_____ Compulsive behaviors	_____ Drug addiction	_____ Sexual Abuse
_____ Alcoholism	_____ Insomnia	_____ Physical abuse
_____ Emotional Abuse	_____ Grief/loss	_____ Eating Disorder
_____ Rejection	_____ Low self Esteem	_____ Mood swings
_____ Anger/Frustration	_____ Work-olism	_____ Career Decision
_____ Occult Oppression	_____ Financial Crisis	_____ Relationships
_____ Abandonment	_____ Adultery	_____ Loss of hope

_____ Thoughts That you don't want to be here any more

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Other Crisis Issues:

Suicidal thoughts, plans, attempts
Yes____No____Explain_____

Homicidal thoughts, plans, attempts
Yes____No____Explain_____

Desire to inflict pain to self or others
Yes____No____Explain_____

_____ In fear of life or personal safety

Yes____No____Explain_____

Too depressed to care for self or family
Yes____No____Explain_____
Have you had any major surgeries, illnesses, or accidents? Please describe

MEDICAL INFORMATION

Family Doctor_____

Psychiatrist/Psychologist_____

Diagnosis______

Are you taking medication Yes____ No____ List medications
_____ Who
is prescribing

_____

Describe your physical
health_____ Have you
taken medication for emotional stress?

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Yes____No____Explain_____

Have you ever been hospitalized for emotional or mental illness or substance abuse?

Yes____No____Explain_____

Additional information that will help us understand your needs and individual issues:

_____

_____

Signature _____ Date _____

Witness _____ *Date* _____

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