FMI CHRISTIAN COUNSELING CENTER

Client Prescreening Questionnaire form

Please complete this form as honestly and completely as you are able to. All information that you provide us will remain confidential as required.

Date:_____ **Social Security Number**: _____

Name:_____ **Date of Birth**:_____ **Age**: _____

Home Address:_____ **City/State/Zip code**: _____

Home Phone:_____ **Cellular/Alternate Phone**: _____

Marital Status: single ☐ married ☐ separated ☐ divorced ☐
remarried ☐ engaged ☐ widowed ☐ cohabiting ☐

If applicable, please complete the following:
Partner's Name: _____ **Partner's Age**: _____

Partner's Occupation: _____

IF YOU HAVE CHILDREN PLEASE LIST THEIR NAMES AND AGES:

#	Name	Sex	Age	#	Name	Sex	Age
1				4			
2				5			
3				6			

WHO CURRENTLY LIVES IN YOUR RESIDENCE (adults and children):

#	Name	Relation	Sex	Age	#	Name	Relation	Sex	Age
1					4				
2					5				
3					6				

In your own words, describe the current problems as you see them:

_____
_____
_____
_____
_____

How long has this been going on? _____

What made you come in at this time? _____
_____
_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____

_____

_____

Symptoms

Please **check** any symptoms or experiences that you have had **in the last month**

- ☐ Difficulty falling asleep
- ☐ Difficulty getting out of bed
  Average hours of sleep per night: _____
- ☐ Difficulty staying asleep
- ☐ Not feeling rested in the morning

- ☐ Loss of interest in once enjoyed activities
- ☐ Withdrawing from other people
- ☐ Depressed Mood
- ☐ Rapid mood changes
- ☐ Anxiety
- ☐ Frequent feelings of guilt
- ☐ Intrusive Memories
- ☐ Spending increased time alone
- ☐ Feeling Numb
- ☐ Irritability
- ☐ Panic attacks
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations (i.e., flying, heights, bugs) Describe: _____
- ☐ Repetitive behaviors or mental acts (i.e., counting, checking doors, washing hands)

- ☐ Outbursts of anger
- ☐ Worthlessness
- ☐ Sadness
- ☐ Avoiding people, places, activities or specific things
- ☐ Hopelessness
- ☐ Helplessness

- ☐ Fear
- ☐ Changes in eating/appetite
- ☐ Eating more
- ☐ Voluntary vomiting
- ☐ Feeling or acting like a different person
- ☐ Eating less
- ☐ Use of laxatives

- ☐ Trying to lose weight? _____
- ☐ Weight gain:_____lbs
- ☐ Weight loss:_____lbs.

- ☐ Difficulty catching your breath
- ☐ Racing thoughts

- ☐ Unusual sweating
- ☐ Increased energy
- ☐ Tremor
- ☐ Frequent worry
- ☐ Increase Muscle tension
- ☐ Excessive exercise to avoid weight gain
- ☐ Easily started, feeling jumpy
- ☐ Decreased energy
- ☐ Dizziness
- ☐ Physical Sensations others do not have

☐ Difficulty concentrating or thinking
☐ Flashbacks
☐ Thoughts about harming or killing yourself
☐ Large gaps in memory
☐ Nightmares
☐ Thoughts about harming or killing someone else

☐ Feeling as if you were outside yourself, detached, observing what you are doing
☐ Feeling puzzled as to what is real and unreal
☐ Persistent, repetitive, intrusive thoughts, impulses, or images
☐ Unusual visual experiences such as flashes of light, shadows
☐ Hear voices when no one else is present
☐ Feeling that your thoughts are controlled or placed in your mind
☐ Feeling that the television or the radio is communicating with you
☐ Difficulty problem solving
☐ Dependency on others
☐ Inappropriate expression of anger
☐ Difficulty or inability to say "no" to others
☐ Sense of lack of control
☐ Abusive relationship
☐ Concerns about your sexuality
☐ Difficulty meeting role expectations
☐ Manipulation of others to fulfill your own desires
☐ Self-mutilation/cutting
☐ Ineffective communication
☐ Decreased ability to handle stress
☐ Difficulty expression emotions

Sexual Orientation: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ I choose not to answer

Please describe any other symptoms or experiences you have had problems with:

_____

_____

_____

FOR THE FOLLOWING QUESTIONS, IF ANSWERED YES, PLEASE DESCRIBE

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?

☐ No ☐ Yes If so:

Name of therapist:_____ Dates of Treatment
Reason for seeking help: _____ _____

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Reason for seeking help: _____ _____

Are you **CURRENTLY** taking **PSYCHIATRIC** medication? ☐ No ☐ YES

Medication	**Dosage**	**How long have you been taking it?**	**Has it been helpful?**

Are you **CURRENTLY** taking **NON-PSYCHIATRIC** medication? ☐ NO ☐ YES

Medication	**Dosage**	**How long have you been taking it?**

Have you been on **PSYCHIATRIC** medication in the past? ☐ NO ☐ YES

Medication	**Dosage**	**First/Last time you took it**	**Effect of Medication**

Have you been hospitalized for psychiatric reasons? ☐ NO ☐ Yes

Hospital	**Dates**	**Reason**

Have you ever attempted suicide? ☐ No ☐ Yes

MEDICAL HISTORY

Are you **CURRENTLY** under treatment for any medical condition? ☐ No ☐ Yes

List any PRIOR illnesses, operations and accidents

FAMILY HISTORY

Father: Age: Living ☐ Deceased ☐ Cause of death:

If deceased, HIS age at time of his death____
Occupation:_____
Frequency of contact with him:_____

YOUR age at time of his death_____
Health:_____
Are you/Have you been close to him? _____

Mother: Age: Living ☐ Deceased ☐ Cause of death:

If deceased, HER age at time of his death____
Occupation:_____
Frequency of contact with him:_____

YOUR age at time of her death_____
Health:_____
Are you/Have you been close to her? _____

Brothers and Sisters

Name	Sex	Age	Whereabouts	Are you close to him/her?			
					No		Yes
					No		Yes
					No		Yes
					No		Yes

During your childhood, did you live any significant period of time with anyone other than your natural parents?

☐ No ☐ Yes If so, please give the person's name and relationship to you

Name:_____ Relationship to you:_____

Please place a check mark in the appropriate box if these are or have been present in your relatives

	Children	Brothers	Sisters	Father	Mother	Uncle/Aunt	Grand parents
Nervous Problems							
Depression							
Hyperactivity							
Counseling							
Psychiatric Medication							
Psychiatric Hospitalization							
Suicide Attempt							
Death by Suicide							
Drinking Problem							

SOCIAL HISTORY

Past Marital History

Have you been married previously? If yes, please describe:

When?_____ How long? _____
When?_____ How long? _____

Education

Highest grade level completed: _____
Degree obtained, if applicable: _____
Did you have any disciplinary problems in school? _____
If yes, please explain: _____
Were you considered hyperactive/ADHD in school? _____
If yes, were/are you on any medication? _____
If yes, were/are you on any medication? _____
If so, which medication? _____
What kinds of grades did you get in school? _____

Have you served or are serving in the military? _____
If yes, please describe briefly: _____
_____

What type of discharge (separation) did you get? _____

Employment

Are you currently employed? _____
If yes, employer's name: _____
What type of work do you do? _____

Employment History (most recent first)

Type of Job	Dates	Reason for Leaving

Have you been arrested? _____
If yes, please describe: _____

Do you have a **Religious Affiliation**? _____
If yes, what is it? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Sexually ☐ Neglected

Please describe: _____

_____

SUBSTANCE ABUSE

Alcohol

Do you drink alcohol?_____ If yes, age of first use _____

How much do you drink? _____

How often do you drink? _____

Have you ever passed out from drinking?_____ How often? _____

Have you ever blacked out from drinking?_____ How often? _____

Have you ever had the "shakes"?_____ How often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing yourdrinking/drug use? _____

Have you ever felt bad or guilty about your drinking/drug use? _____

Have you ever drank/used drugs in the morning to steady your nerves or relievea hangover? _____

Do you use tobacco? _____

If yes, how often? _____

Other Drugs:

Please indicate for each drug listed below

Drug	Ever Used?	Age at 1st use	Time Since Last Use	Approx use in last 30 days
Marijuana				
Cocaine				
Crack				
Heroin				
Methamphetamine				
Ecstasy				
Other not listed				

Is there anything else you would like us to know about you?
Feel free to comment below:

The Holmes-Rahe Scale

Read each of the events listed below, and **check the box** next to any even which has occurred in your life **in the last two (2 - 3) years.** There are no right or wrong answers. The aim is to identify which of these events you have experienced lately.

Life Events	Life Crisis Units	
Death of Spouse	100	
Divorce	73	
Marital Separation	65	
Gone to jail	63	
Death of close family member	63	
Personal injury or illness	53	
Marriage	50	
Fired at work	47	
Marital reconciliation	45	
Retirement	45	
Change in health of family member	44	
Pregnancy	40	
Sexual Difficulties	39	
Gain of new family member	39	
Business readjustment	39	
Change in financial state	38	
Death of a close friend	37	
Change to different line of work	36	
Increase in arguments with spouse	35	
Mortgage over $100,000	31	
Foreclosure of mortgage or loan	30	
Change in responsibilities at work	29	

Life Events	Life Crisis Units	
Son or daughter leaving home	29	
Trouble with in-laws	29	
Outstanding personal achievement	28	
Spouse begins or stops work	26	
Begin or end school	26	
Change in living conditions	25	
Revision in personal habits	24	
Trouble with boss	23	
Change in work hours or conditions	20	
Change in residence	20	
Change in schools	20	
Change in recreation	19	
Change in church activities	19	
Change in social activities	18	
Mortgage or loan less than $30,000	17	
Change in sleeping habits	16	
Change in number of family get-togethers	15	
Change in eating habits	15	
Vacation	13	
Christmas alone	12	
Minor violations of the law	11	

Your Total Score: _____