

LIGHTHOUSE COUNSELING SERVICES

“BRINGING HOPE AND DIRECTION DURING STORMY TIMES”

Please list everyone in your family:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

What problems are you experiencing? (Please Circle)

ANXIETY, DEPRESSION, MEMORY PROBLEMS, ABUSE, SUICIDAL THOUGHTS, VIOLENT THOUGHTS, SLEEP PROBLEMS, EATING PROBLEMS, HOPELESSNESS, FATIGUE, GUILT, SHAME, ANGER, FOCUSING PROBLEMS, FEARS, NIGHTMARES, DRUG PROBLEMS, SEXUAL PROBLEMS, WORK PROBLEMS, RELATIONAL PROBLEMS, PARENTING PROBLEMS.

OTHER: _____

LIST ANY SIGNIFICANT MEDICAL HISTORY OF YOURSELF AND YOUR FAMILY:

CURRENT MEDICATIONS:

WHAT DO YOU HOPE TO GET FROM THERAPY?

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