KM Counseling
1224 Centre West Drive, Ste.200-E
Springfield, IL 62704
217.717.4399

INTAKE FORM FOR PARENT AND ADOLESCENT (ages 12+)

This intake form requires information on **BOTH** parent/guardian and adolescent. Please **read each section carefully** to understand which section pertains to you and which selection pertains to your adolescent.

CUSTODIAL PARENT/GUARDIAN INFORMATION (Who has legal custody of this adolescent)

☐ Both Parents ☐ Mother ☐ Father ☐ Other (complete info. in box)

First Name: _____ MI: _____ Home PH: _____

Last Name: _____ Work PH: _____

Address: _____ DOB: _____ /_____ /_____

_____ ____ Male ____ Female

City: _____ State: _____ Zip: _____

Relation to Client: _____

BIOLOGICAL PARENT INFORMATION

Mother

First Name: _____ Last Name: _____

D.O.B. (mm/dd/yyyy) _____ / _____ / _____

Address:_____ Home PH: _____

_____ Cell PH: _____

Occupation: _____ How Long: _____

Place of Employment: _____

Education (highest grade or degree completed): _____

Other Education or Training: _____

MARITAL STATUS: ____ Married ____ Single ___ Divorced ____ Widowed ____ Co-Habitating

If married: wedding date: _____ / _____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are co-habitating:

Name: _____

Get along with client? ____ Yes ____ No

Father

First Name: _____ Last Name: _____

D.O.B. (mm/dd/yyyy) _____ / _____ / _____

Address:_____ Home PH: _____

_____ Cell PH: _____

Occupation: _____ How Long: _____

Place of Employment: _____

Education (highest grade or degree completed): _____

Other Education or Training: _____

MARITAL STATUS: ____ Married ____ Single ___ Divorced ____ Widowed ____ Co-Habitating

If married: wedding date: _____ / _____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are co-habitating:

Name: _____

Get along with client? ____ Yes ____ No

ADOLESCENT/CLIENT INFORMATION

First Name: _____ Last Name: _____

Gender: ____ Male ____ Female D.O.B. (mm/dd/yyyyy): _____ / ____ / _____

School: _____ Grade: _____

Physician(s) of ADOLESCENT: _____

ADOLESCENT'S MEDICATIONS

Current Medications

Medication	Dosage	Frequency

Past Medications

Medication	Dosage	Frequency

List all persons living in the home with adolescent:

Name	Age	Sex	Relationship to adolescent

List other children not in the home:

Name	Age	Sex	Relationship to adolescent

CHECK ANY OF THE FOLLOWING BEHAVIORS THAT ARE TRUE OF YOUR TEEN

_____ Affectionate
_____ Angry
_____ Argues, "talks back", smart-alecky, defiant
_____ Blames others for his/her actions
_____ Bored
_____ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
_____ Cheats
_____ Clings to you too much
_____ Cruel to animals
_____ Concern for others
_____ Conflicts with parents – over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
_____ Complains
_____ Confused
_____ Cries easily, feelings are easily hurt
_____ Dawdles, procrastinates, wastes time
_____ Difficulty with parents' new marriage/new family
_____ Dependent, immature
_____ Developmental delays

_____ Disrupts family activities
_____ Disobedient, uncooperative, refuses, non-compliant, doesn't follow rules
_____ Distractible, inattentive, poor concentration, daydreams, slow to respond
_____ Dropping out of school
_____ Drug or alcohol use
_____ Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overats
_____ Exercise problems
_____ Extracurricular activities interfere with academics
_____ Failure in school
_____ Fearful
_____ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
_____ Fire setting
_____ Friendly, outgoing, social
_____ Guilty
_____ Hard time making and keeping friends
_____ Headaches
_____ Hypochondriac, always complains of feeling sick
_____ Immature, "clowns around", has only younger playmates
_____ Imaginary playmates
_____ Independent
_____ Interrupts, talks out, yells
_____ Lacks organization, unprepared
_____ Lacks interest in things he/she used to like
_____ Lacks remorse
_____ Lacks respect for authority, insults, dares, provokes, manipulates
_____ Learning disability
_____ Legal difficulties: truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
_____ Likes to be alone, withdraws, isolates
_____ Lying
_____ Low frustration tolerance, irritability
_____ Moody
_____ Mute, refuses to speak
_____ Nail biting
_____ Nervous
_____ Nightmares
_____ Need for high degree of supervision at home
_____ Obedient
_____ Obesity
_____ Overactive, restless, hyperactive, out-of-seat behaviors, fidgety, noisiness
_____ Oppositional, resists, refuses, does not comply, negativism
_____ Prejudiced, bigoted, insulting, name calling, intolerant
_____ Pouts
_____ Recent move, new school, loss of friends
_____ Relationships with siblings and/or peers are poor – competition, fights, teasing, assaults
_____ Responsible

_____ Runs away
_____ Sad, unhappy
_____ School problems
_____ Sees or hears things that aren't there
_____ Self-harming behaviors – biting or hitting self, head banging, scratching self, cutting, hair pulling
_____ Speech difficulties
_____ Sexual – sexual preoccupation, public masturbations, inappropriate sexual behaviors
_____ Shy, timid
_____ Sleeping trouble: too much or too little
_____ Stomach aches
_____ Strange thoughts
_____ Stubborn
_____ Suicide talk or attempt
_____ Swearing, foul language
_____ Temper tantrums, rages
_____ Thumb sucking, finger sucking, hair chewing
_____ Tics – involuntary rapid movements, noises, or word productions
_____ Teased, picked on, victimized, bullied
_____ Truant – school avoiding
_____ Underactive – slow-moving, slow-responding, lethargic
_____ Uncoordinated, accident-prone
_____ Vomits often
_____ Wetting or soiling the bed or clothes
_____ Will not eat
_____ Withdraws
_____ Work problems – employment, workaholism/overworking, can't keep a job
_____ Rocking or other repetitive movements

Other:

Is there anything causing your family stress right now? ____ Yes ____ No

Explain: _____

_____

_____

Has this teen been subject to neglect, physical, sexual, or emotional abuse? ____ Yes ____ No

If "yes", what form? _____

Is this child at risk for out-of-home placement because of behavior problems? ____ Yes ____ No

If "yes", please explain: _____

_____

_____

What are your teen's assets or strengths? ____

____

____

What have you found to be satisfactory ways to help your teen? __________________________

____

____

COMMENTS: (*Please write anything else you want us to be aware of in this space*)

____

____

____

____

____

____

How were you referred to this center? ____

____

Have you previously sought counseling for your adolescent before? If "YES", Where and When?

____

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THE FOLLOWING PAGES: "Adolescent Confidential Questionnaire"

ARE TO BE COMPLETED BY ADOLESCENT

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KM COUNSELING
1224 Centre West Drive
Suite 200-E
Springfield, IL 62704
Phone: 217.717.4399

AUTHORIZATION FOR THE RELEASE/EXCHANGE OF INFORMATION

I understand that my records are protected under HIPAA and the Illinois Department of Mental Health & Developmental Disabilities Confidentiality Act and that they cannot be disclosed without my written consent, unless otherwise provided for in the regulations and/or under state specific provisions. I understand that my records may contain information regarding my mental health, substance use or dependence, sexuality, suicidality, and may contain confidential HIV (AIDS) infectious diseases related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below.

I authorize **KM COUNSELING / KATHARINE MARTIN** to release / exchange information with:

TO/FROM: _____(_____)_____
PROVIDER NAME PHONE#

_____,_____
STREET ADDRESS CITY, STATE, ZIP CODE

RE: _____ _____ /_____/_____
CLIENT NAME DATE OF BIRTH

The following types of information:

☐ Complete record ☐ Treatment Summary ☐ Initial Evaluation ☐ Oral Communication only
☐ Other: _____

This information will be used for the purpose of evaluation, treatment and continuity of care (or):_____
_____

Further, I understand that refusal to consent to release of information will result in records not being released. If you consent to release your records, but do not wish certain information to be released, state type of information to be *excluded*:_____

I understand that the information or records above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited. I understand that this consent is revocable at any time PRIOR to the release of information. This authorization will expire ONE YEAR from the date below. I hereby release you and your personnel from all legal responsibility or liability that may arise from the act I have authorized above.

_____ _____ TYPED NAME
Signature of Client (age 12yrs & older) Date

_____ _____ _____ _____
Parent/Guardian/Legal Representative Date Witness Date

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CLIENT DIRECTIVES FOR CONFIDENTIALITY

KM COUNSELING/KATHARINE MARTIN may contact you with an appointment reminder the day prior to your appointment. Also, billing statements are sent out monthly, unless the account has a zero balance. Because of the sometimes delicate nature of our practice, please indicate your preferences below to protect your confidentiality.

Please read the following three sections carefully and indicate your preferences for each directive:

1.Telephone / Text / Email reminder calls:

☐ It is OK to text appointment reminders (list mobile number): (_____)_____--_____

☐ Check if you have special instructions (indicate the numbers to contact you and any special instructions to use when calling): _____

2.Billing statements (for statements other than those with a zero balance):

☐ It is OK to mail billing statements to your residence.

☐ Check if you do not wish to have the billing statement mailed to your home (indicate the special arrangements you prefer): _____

3. Other mailings from the office

☐ It is OK to mail information to your residence.

☐ Check if there are special instructions (indicate your preferences): _____

4.Consent to Authorize Release of Information

☐ I am willing to sign a release for KM Counseling / Katharine Martin, Provider to communicate with your Primary Care Physician, *if needed*. (Signed Authorization to Release Information required).

☐ Check if you decline to give consent to Authorize Release of Information at this time.

I have read and checked my preferences regarding the four items detailed above.

_____ _____

Printed name Date

_____

Signature of Patient (or legal Representative - state relationship)

For Office Use Only

Accept☐ Refuse☐ Reason:

Privacy Officer: Signature_____ Date_____

CLIENT FINANCIAL AGREEMENT

Payment of session fees, insurance co-payment, coinsurance and deductible, or other charges are due at the time of service unless prior arrangements have been made with Katharine Martin/KM COUNSELING. Verification of insurance coverage and referrals is the responsibility of the client.

There will be a $ 35.00 charge for all checks returned for any reason.

There may be a charge for telephone consultations over 10 minutes. Insurance plans will not cover these charges.

A statement will be sent on a monthly basis. You are financially responsible for all charges. This may include a balance remaining after payment of insurance benefits, charges for non-covered services or missed appointments, and any billing charges, collection agency fees of up to 60% of the delinquent balance, and legal fees related to payment of your account in full. All delinquent accounts will accrue added billing charge of 1.5% on a monthly basis. If payments are not made as agreed, your account may be turned over to a collection agency after 90 days delinquency.

Mental Health Evaluation/Assessments/Consultations: Reports for probation, court, disability, FMLA, and letters to physicians, teachers, schools and completion of paperwork are pro-rated for the amount of time taken to prepare the report. All reports and court testimony must be paid in advance of receipt of report or court testimony.

____ (*initial*) **If you need to reschedule or cancel an appointment, I require a 24-hour notice.** If I have notice, I can offer the time to another client. Failure to provide notice will result in a full charge for the missed appointment. This charge may be waived in the case of illness, unforeseen sudden circumstance, or emergency.

INSURANCE INFORMATION

Insured Name and Address of primary person:

_____

_____

Employer:

_____

Insurance company:

_____

Please provide a copy of your insurance card and photo ID.

If different than client, Insured Relationship to Client:

_____

Insured DOB:_____

Insured phone#:(____)_____

Insurance Policy number:_____

Insurance Group number: _____

By signing here I agree to the policies set forth in the Financial Agreement, **and** I authorize KM COUNSELING/KATHARINE MARTIN to use or disclose my personal health information to my health insurance carrier or other covered entity for the purpose of continued care and payment. I understand I am financially responsible for charges not covered by this authorization.

_____ _____ _____

Print Client Name Client/Guarantor Signature

_____ _____ _____

Print Parent/Guarantor Name (if child or other) Guarantor Relationship to Client Date

Edited 01/2022

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Adolescent Confidential Questionnaire

Please fill out the following questions about yourself as completely as possible by writing, checking, or circling the correct answer. This will help the counselor get to know you better.

Name: _____ Date: ____ / ____ / ____

Address: _____ Birthday: ____ / ____ / ____

_____ Age: _____

Mobile Phone: _____

Whose idea was it for you to come here?

____ Mine
____ Parent(s)
____ other – who? _____

How do you feel about being here?

____ It's fine with me
____ I don't care either way
____ I'm against it

Briefly describe what is happening in your life that brings you to counseling.

_____

_____

_____

_____

_____

_____

How long has this been a problem?

_____

_____

_____

SCHOOL INFORMATION

What school do you attend? _____ Grade: _____

What do you like about school?

_____

_____

What do you dislike about school?

_____

_____

What activities (if any) are you in at school? _____

_____

ACTIVITIES & INTERESTS

What do you do for fun?

_____

_____

What kind of music do you listen to? _____

Who are 3 of your favorite artists/groups? _____

_____

_____

Do you attend a church? ____ Yes ____ No

If "yes", what is the name of your church? _____

HEALTH

How would you rate your overall health? ____ excellent ____ good ____ fair ____ poor

Have you had any recently weight gain or loss? ____ Yes, weight gain ____ Yes, weight loss ☐ No

If "yes", how much? _____

FRIENDS

How much time to you spend with friends? ____ a lot ____ some ____ not much

Do you have a best friend? ____ Yes ____ No
If "yes," how long have you known him/her? _____

Do you have a boyfriend/girlfriend? ____ Yes ____ No
If "yes," how long have you been dating? _____

Do people at school tend to label your group of friends (skaters, preps, etc.)? ____ Yes ____ No
If, so, what label are they usually given? _____

FAMILY

List all the people living with you (excluding yourself).

Name	Age	Sex	Relationship

Describe your relationship with your father:

_____

_____

Describe your relationship with your mother:

_____

_____

If you have brothers or sisters, describe your relationship with them:

_____

_____

If you have step-parents, describe your relationship with them:

_____

_____

What relative (not including your parents, brothers, or sisters) are you closest?

_____

Why?

FEELINGS

Check all the feelings you often have:

____ happy	____ irritable	____ confused	____ hyper/energetic
____ worried	____ sad	____ anxious/nervous	____ confident
____ guilty	____ lonely	____ angry	____ bored
____ shy	____ depressed	____ worthless	____ hopeless

Check all the FEARS that you often have:

____ Dark	____ New situations	____ Spending the night away from home
____ Being alone	____ Death	____ Separation from parent
____ School	____ Animals	____ Visiting a friend's home
____ Strangers	____ Other: _____	

DRUG and ALCOHOL USE

How often do you drink alcohol?	☐ never	☐ tried it	☐ rarely	☐ monthly	☐ weekly	☐ daily
How often do you use cigarettes/vape?	☐ never	☐ tried it	☐ rarely	☐ monthly	☐ weekly	☐ daily
How often do you smoke marijuana?	☐ never	☐ tried it	☐ rarely	☐ monthly	☐ weekly	☐ daily
How often do you use other drugs?	☐ never	☐ tried it	☐ rarely	☐ monthly	☐ weekly	☐ daily

---

OTHER INFORMATION

List any major changes in your life over the last 5 years:

_____

_____

_____

If there is any other information you believe would be helpful for the therapist to know, please use the space below to provide it (use back if you need).

_____

_____

_____

PROBLEM CHECKLIST - ADOLESCENT

Name: _____ Date: _____

In an effort to be helpful to you, it is important that we get a good idea about the things that are happening in your life. Please be as honest as possible.
Please check the items that you have experienced in the *anytime* in your life, and/or have experienced in the *past six months*.

Anytime	6 Months	
☐	☐	I Do Not Get Along With Other People
☐	☐	I Feel Criticized By Others
☐	☐	I Do Not Fit In With My Peers
☐	☐	I Have A Bad Reputation
☐	☐	I Feel Uncomfortable In Social Settings
☐	☐	I Feel Immature
☐	☐	I Am Shy
☐	☐	I Do Not Have Close Friends
☐	☐	I Feel Taken Advantage Of By Friends
☐	☐	I Do Not Have Anyone That Shares My Interests
☐	☐	I Feel Lonely
☐	☐	I Feel Unpopular
☐	☐	I Feel Uncomfortable Talking To Others
☐	☐	I Feel Inferior
☐	☐	I Feel Like People Are Against Me
☐	☐	I Am Embarrassed By My Family Background
☐	☐	I Feel Let Down By My Friends
☐	☐	I Feel Different From Everyone Else
☐	☐	I Feel Pressure To Do Wrong Things
☐	☐	I Have A Poor Attitude About Everything
☐	☐	I Do Not Have Any Interest In Things
☐	☐	I Have Had A Recent Change In Attitude
☐	☐	I Do Not Listen To Opinions Of Others
☐	☐	I Do Not Have Opinions About Anything
☐	☐	I Have Different Opinions Than Others
☐	☐	I Do Not Understand The Attitudes Of Others
☐	☐	I Have A Poor Attitude Towards Religion
☐	☐	I Have A Poor Attitude Towards School
☐	☐	I Have A Poor Attitude Towards Work
☐	☐	I Have A Poor Attitude Towards Family
☐	☐	I Have A Poor Attitude Towards Myself
☐	☐	I Feel I Am Overweight
☐	☐	I Feel I Am Too Short Or Too Tall
☐	☐	I Have A Physical Handicap
☐	☐	I Feel I Am Too Thin
☐	☐	I Look Too Young Or Too Old
☐	☐	I Feel I Am Noticed For My Looks
☐	☐	I Feel I Look Too Plain
☐	☐	I Feel I Am Clumsy And Awkward
☐	☐	I Feel I Am Not Clean And Well Groomed
☐	☐	I Do Not Feel I Have The Right Clothes
☐	☐	I Feel Ugly/Unattractive

Anytime	6 Months	
☐	☐	My Father/Mother Is Sick
☐	☐	My Father/Mother Is Having Emotional Problems
☐	☐	My Father/Mother Is Having Problems With Drugs
☐	☐	My Father/Mother Is Having Problems With Alcohol
☐	☐	My Parents Fight Or Argue
☐	☐	My Parents Are Separated Or Are Getting A Divorce
☐	☐	My Parents Are Divorced
☐	☐	I Have Problems With My Stepmother/Stepfather
☐	☐	My Parents Are Never Home
☐	☐	I Do Not Feel Like I Can Talk To My Parents
☐	☐	My Parents Are Too Strict
☐	☐	My Parents Interfere With My Decisions
☐	☐	My Parents Expect Too Much Of Me
☐	☐	My Parents Disapprove Of My Boyfriend/Girlfriend/Dating
☐	☐	My Parents Disapprove Of My Friends
☐	☐	My Parents Disapprove Of My Job
☐	☐	My Parents Disapprove Of The Way I Look And/Or Dress
☐	☐	My Parents Disapprove Of The Music I Listen To
☐	☐	My Parents Disapprove Of Activities
☐	☐	My Parents Favor My Brother/Sister
☐	☐	My Parents Ignore Me
☐	☐	I Argue A Lot With My Brother/Sister
☐	☐	My Brother/Sister Is Stealing
☐	☐	I Feel Bothered By My Brother/Sister
☐	☐	My Family Fights/Argues A Lot
☐	☐	I Have Problems With My Other Family Members
☐	☐	I Do Not Feel I Have Any Privacy
☐	☐	I Have To Do Household Chores
☐	☐	I Do Not Feel Close To My Family
☐	☐	I Feel My Family Does Not Have Enough Money
☐	☐	My Father/Mother Has Lost Their Job
☐	☐	I Do Not Want To Live At Home
☐	☐	I Feel Like I Live In A Bad Neighborhood
☐	☐	I Am Old Enough To Drive, But Not Allowed
☐	☐	I Have Been Robbed
☐	☐	I Have Been In Trouble With The Police
☐	☐	I Have Run Away
☐	☐	My Brother/Sister Have Run Away
☐	☐	I Have A Physical Health Problem
☐	☐	I Have A Long Term Illness
☐	☐	I Am Often Sick
☐	☐	My Family Is Often Sick

Anytime	6 Months	
☐	☐	I Get Bad Grades
☐	☐	I Do Not Get Along With My Teachers
☐	☐	I Do Not Have Good Study Habits
☐	☐	I Do Not Have A Quiet Place To Study
☐	☐	I Feel I Am Taking The Wrong Classes
☐	☐	I Am Not Interested In School Clubs Or Teams
☐	☐	I Do Not Qualify For Clubs Or Teams
☐	☐	I Do Not Have Any Close Friends At School
☐	☐	I Feel My School Is Too Large
☐	☐	I Am Missing School Because Of Being Sick
☐	☐	I Do Not Understand Class Material
☐	☐	I Do Not Understand Remote/eLearning
☐	☐	I Do Not Get Along With Other Students
☐	☐	I Feel Out Of Place In School
☐	☐	I Am Not Interested In School
☐	☐	I Feel I Have A Language Problem In School
☐	☐	I Feel My Teachers Do Not Care About The Students
☐	☐	I Feel I Am In The Wrong School
☐	☐	I Am Bored In School
☐	☐	My School Is Too Far From Home
☐	☐	I Worry About Future Jobs Or College
☐	☐	I Have Trouble Budgeting Money
☐	☐	I Feel I Do Not Make Enough Money
☐	☐	I Do Not Have A Steady Income
☐	☐	I Feel I Have To Spend My Savings
☐	☐	I Owe Money
☐	☐	I Feel I Waste Money
☐	☐	I Feel I Depend On Others For Money
☐	☐	I Lend Money To Friends Or Family
☐	☐	I Feel I Have To Give Money To My Parents
☐	☐	I Do Not Have Enough Money For Personal Things
☐	☐	I Do Not Like My Job
☐	☐	I Feel My Job Does Not Pay Enough
☐	☐	I Do Not Like My Boss
☐	☐	I Do Not Like My Job Being Dirty
☐	☐	I Do Not Like My Co-Workers
☐	☐	I Feel I Am Disliked By My Co-Workers/Boss
☐	☐	I Am Afraid Of Being Fired/Laid Off
☐	☐	I Am Afraid Of Failing At My Job
☐	☐	I Do Not Want To Work
☐	☐	I Do Not Have A Way To Get To Work
☐	☐	I Feel My Friends Have Better Jobs
☐	☐	I Feel I Work In Unsafe Conditions
☐	☐	I Worry I Will Get/Exposed To Covid At Work
☐	☐	I Feel There Is A Lack Of Supervision At My Job
☐	☐	I Feel My Boss Is To Critical Or Unfair
☐	☐	I Have Arguments While On The Job
☐	☐	I Feel I Work Too Many Hours
☐	☐	I Feel My Job Is Creating Health Problems
☐	☐	I Am Bored With My Job
☐	☐	I Feel I Lack The Experience To Get A Good Job
☐	☐	I Feel I Have No Future With My Current Job
☐	☐	I Feel Uncomfortable With My Sexuality
☐	☐	I Am Not Able To Date
☐	☐	I Do Not Have Anyone To Date/Lonely
☐	☐	I Am Having Problems With My Boyfriend/Girlfriend
☐	☐	I Want To Break Up With My Boyfriend/Girlfriend

Anytime	6 Months	
☐	☐	I Worry About Getting Pregnant
☐	☐	I Am Pregnant/My Girlfriend Is Pregnant
☐	☐	I Feel I Do Not Know Enough About Sex
☐	☐	I Am Confused About Sex/Sexuality
☐	☐	I Feel I Think About Sex Too Often
☐	☐	I Worry About Being Homosexual/Bi/Trans
☐	☐	I Am Troubled By The Sexual Attitudes Of Friends
☐	☐	I Am Troubled By Unusual Sexual Behavior
☐	☐	I Feel I Am Sexually Underdeveloped
☐	☐	I Feel Used
☐	☐	I Feel Pressured Into Having Sex
☐	☐	I Do Not Have Any Religious Beliefs
☐	☐	I Argue With My Parents About My Religious Beliefs
☐	☐	I Am Confused About My Religious Beliefs
☐	☐	I Feel I Am Failing In My Religious Beliefs
☐	☐	My Boyfriend/Girlfriend Has Different Religious Beliefs
☐	☐	I Argue With My Boyfriend/Girlfriend About Religion
☐	☐	I Am Not Able To Get To Church
☐	☐	My Chores Interfere With My Church Activities
☐	☐	My Job Interferes With Church Activities
☐	☐	I Get Upset By The Religious Beliefs Of Others
☐	☐	I Worry About Being Accepted By God
☐	☐	I Feel I Am Being Rejected By Church Members
☐	☐	I Do Not Have Any Friends At Church
☐	☐	I Feel Anxious Or Uptight
☐	☐	I Feel Afraid Of Things
☐	☐	I Have The Same Thoughts Over And Over Again
☐	☐	I Am Tired And Have No Energy
☐	☐	I Feel Depressed Or Sad
☐	☐	I Have Trouble Concentrating
☐	☐	I Have Trouble Remembering Things
☐	☐	I Feel I Get Too Emotional
☐	☐	I Worry About Diseases Or Illnesses
☐	☐	I Have Nightmares
☐	☐	I Think Too Much About Death And Dying
☐	☐	I Am Afraid Of Hurting Myself
☐	☐	I Feel Things That Are Not Real
☐	☐	I Cry Without Good Reason
☐	☐	I Worry About Having A Nervous Breakdown
☐	☐	I Am Not Able To Stop Worrying
☐	☐	I Am Not Able To Relax
☐	☐	I Fell I Am Unhappy All Of The Time
☐	☐	I Do Not Have Any Enjoyment In Life
☐	☐	I Feel I Am Influenced By Others
☐	☐	I Feel I Behave In Strange Ways
☐	☐	I Feel Out Of Control
☐	☐	I Feel Afraid Of Hurting Someone Else
☐	☐	I Feel I Could Lose My Temper And Hurt Someone
☐	☐	My Friend/Family Member Committed Suicide
☐	☐	My Friend/Family Member Has A Serious Illness
☐	☐	My Friend/Family Member Is Getting Divorced
☐	☐	My Friend/Family Member Is Dying
☐	☐	My Pet Is Dying/Died
☐	☐	I Am Being Physically Hurt/Abused
☐	☐	I Cannot Trust Others
☐	☐	I Do Not Feel Safe
☐	☐	I Cannot Talk To Others

Anytime	6 Months	
☐	☐	I Have Thoughts About Suicide
☐	☐	I Plan On Hurting Someone Else
☐	☐	I Do Not Have Any Appetite
☐	☐	I Binge Eat
☐	☐	I Throw Up Frequently
☐	☐	I Feel I Eat Too Much
☐	☐	I Feel I Have Poor Eating Habits
☐	☐	I Feel I Do Not Get Enough Exercise
☐	☐	I Do Not Have Time To Relax
☐	☐	I Sleep Too Much
☐	☐	I Have Poor Sleeping Habits

Anytime	6 Months	
☐	☐	I Use/Abuse Alcohol / Drugs
☐	☐	I Smoke Cigarettes/Vape/Chew Tobacco
☐	☐	I Am Not Able To Get Enough Sleep
☐	☐	I Have To Take Medication
☐	☐	I Am Unhappy With My Doctor(s)
☐	☐	I Feel I Watch To Much TV
☐	☐	I Do Not Have Any Hobbies
☐	☐	I Do Not Have Time For Interest/Hobbies
☐	☐	I Worry About Getting Covid
☐	☐	I Am Doing Remote Learning For School
☐	☐	I Worry About Ability To Learn

Please List Any Other Problems You Might Be Experiencing:

Following therapy/counseling, what would you like to see changed about your life and situation?